Working with communities to improve health

Annual Public Health Report 2010 for Suffolk

Forest Heath
St Edmundsbury
Mid Suffolk
Babergh
Ipswich
Waveney
Suffolk Coastal

Suffolk County Council
NHS Suffolk
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As I write this introduction, we are waiting for major changes in public health policy in England. The forthcoming 'Public Health White Paper' to be published in 2010, will almost certainly emphasise that health is not solely determined by health behaviours such as smoking, physical activity, diet, sexual behaviour and drinking alcohol.

Health is also heavily influenced by the physical environment, including poor housing, poor transport, poor planning, climate change; and by the social environment such as fragmented communities, unemployment, poor skills, low income, loneliness, poor housing, high crime, poor access to leisure and cultural activities, discrimination and family breakdown. It is anticipated that the forthcoming White Paper will give local authorities more freedom on how they improve the health of their communities. New Health and Wellbeing Boards, led by local authorities, will monitor progress in achieving better health outcomes.

This report looks at how different opportunities and chances throughout life influence the health of people in Suffolk, and includes the effects of health behaviour, physical and social environments. We also give information about the health of people in Suffolk and in each local authority area. In this report, data refers to Suffolk county, unless stated otherwise. In some instances, data for the NHS Suffolk area rather than Suffolk county is presented, and this is clearly indicated in the text.

The content of this report was chosen for two main reasons:

- First, to recognise the contribution of district and borough councils, local strategic partnerships and the voluntary sector, towards making Suffolk the healthiest county.

- Second, we report on a ground-breaking public health report published in 2010, 'Fair Society, Healthy Lives', written by Sir Michael Marmot. Referred to as the Marmot Review, the report shows that in England and Wales, the difference in life expectancy between the richest and poorest - called the health inequalities gap - has not decreased in the last 30 years. Each year in England, it is estimated that the health inequality gap leads to between 1.3 and 2.5 million years of life lost, productivity losses of £31-33 billion, reduced tax revenue and higher welfare payments of £20-32 billion, as well as increased NHS treatment costs, well in excess of £5 billion.

The review also describes how better health is far more likely to be achieved when people have control of their lives, have better social conditions and feel responsible for their own health and lifestyle.

In this report, we consider best practice in supporting communities to improve their health, including many local examples. We have developed a full profile of health and health inequalities by district, which includes local information on the social determinants of health. We have also undertaken a case study of Mid Suffolk, to try to find out why people there enjoy good health and such a high quality of life. The district was reported in the 'Halifax Quality of Life Survey' 2009 as having the best quality of life in English rural areas. If we can shed light on why this is, we may be able to transfer important knowledge to other areas.

This work has been carried out with University Campus Suffolk, the Suffolk borough and district councils, Suffolk local strategic partnerships, NHS Suffolk, NHS Great Yarmouth and Waveney, and Suffolk County Council. Contributions have also been received from a number of voluntary organisations.

I hope that you enjoy reading this report.
Developing local strategies to promote better mental health

Healthy Ambitions Suffolk continues to grow, promoting health and wellbeing, including mental health, across the community. In addition, NHS Great Yarmouth and Waveney are also currently involving stakeholders in writing a mental health promotion strategy.

Nationally, in 2008-09, stress, depression and anxiety accounted for 35% of self-reported work related illness (second only to musculoskeletal injury), and mental illness was the most common cause (57%) of GP certified days absence from work between 2006 and 2008 (Health and Safety Executive Statistics 2008-09, HSE 2009).

It therefore makes sense to make Suffolk’s workplaces a locus for Healthy Ambitions Suffolk.

Our Healthy Ambitions Suffolk computerised Health Manager, includes mental health as a major component, and is an on-line personal trainer offering a health assessment, advice and support to any Suffolk resident.

In 2009, work began and continues through our newly appointed Fit-for-Work Coordinator, to bring the on-line Health Manager into businesses, particularly those in deprived areas or employing staff on lower than average pay.

We are grateful to be working with the Suffolk Chamber of Commerce to progress this work.

Our business awards, encouraging employers to provide a healthy workplace, have mental health as an important criterion for assessment. In 2009, the first year of the award scheme, seven local organisations and businesses achieved a gold award, and two obtained silver.

More information on Healthy Ambitions Suffolk and the business awards can be found at http://www.healthyambitionssuffolk.nhs.uk
Local strategies to help the unemployed

Representatives of mental health, employment and business services have developed an employment strategy for Suffolk. This aims to ensure a comprehensive approach to help all people with diverse mental health needs, aiming to:

• prevent onset of mental ill health due to unemployment
• support young people who are finding it difficult to enter the job market
• retain their existing job
• gain work experience, adult learning/training and opportunities to volunteer.

This strategy will achieve this by offering discrete support services, working with employers, encouraging the public sector to become an exemplar employer for people with mental health problems and providing targeted information to employers.

A prioritised list for mental health service developments

A Mental Health Commissioning Strategy has been agreed by the joint Mental Health Partnership Board, and action plans are being developed. Work areas are being informed by the following key themes in the national strategy for mental health published in 2009, ‘New Horizons: a shared vision for mental health’ (Department of Health 2009).

A workshop, bringing together users and carers, representatives of Suffolk County Council, voluntary and NHS providers, NHS Suffolk and NHS Great Yarmouth and Waveney, was held in April 2010.

The objectives of the workshop were to consolidate the vision for mental health in Suffolk, to understand current developments and good practice already in place, and to develop a shared approach which establishes priorities and key deliverables. The themes considered in the workshop were:

• mental wellbeing for children and young people
• how we develop approaches which support recovery from mental illness
• supporting people to find suitable housing and employment
• the needs of informal carers
• how to promote wellbeing and develop early intervention, through Healthy Ambitions Suffolk
• the needs of disadvantaged groups, including challenging the stigma of mental illness
• how to address the risk of mental health problems, particularly depression, in older people.

The emerging themes were the importance of partnership working and seamless access to services for users and carers, the need for effective and cost-effective services, and the importance of prevention in all settings.

Community development workers

NHS Suffolk and NHS Great Yarmouth have appointed community development workers for black and minority ethnic groups. They are working with local communities to understand their experiences of mental health, in order to ensure that services are able to address the diverse needs of the community, promote mental health and better facilitate access to services.

Suicide prevention

A process of audit has been established, based on the national suicide audit toolkit (‘Preventing suicide: a toolkit for mental health services’ National Patient Safety Agency 2009). This will be used jointly to build on the existing process at the mental health trusts and primary care trusts, to learn lessons and develop prevention strategies.
Educational opportunities for staff

The workshop held in April gave staff opportunities to share ideas and experience, and to further develop the understanding of culturally appropriate care. Suffolk Mental Health Partnership NHS Trust (SMHPT) continues to offer all staff ongoing education and development. NHS Suffolk has appointed GP advisers in mental health who will support the development of expertise in primary care. Practices have been informed about care pathways and approaches as part of the establishment of primary care link workers and the Suffolk Improving Access to Psychological Therapies service.

Housing

Supported housing services in Suffolk are being re-tendered. A needs assessment has been undertaken and new service specifications have been completed, in order to offer more flexible support for people, according to their needs.

Monitoring health

NHS Suffolk and Suffolk County Council continue to monitor health and changes in health, through analysis of information and health needs assessment, available through the Joint Strategic Needs Assessment.

Supporting local employers

The mental health employment strategy steering group has worked with representatives of local employers through the Chamber of Commerce, in order to consider their needs in supporting employees with mental ill health and helping all employees to maintain their mental wellbeing.

Child and adolescent mental health

A new strategy for child and adolescent mental health has led to much greater awareness of the importance of promoting mental wellbeing and not just treating mental illness. The strategy has involved a wide range of partners, and emphasises the responsibility of all professionals in contact with children and young people to promote mental wellbeing, as well as to ensure early identification, support and intervention for those who require additional mental health support. In addition to this, the strategy has led to improved services for children and young people who need treatment for behavioural problems or mental illness.

Suffolk Mental Health Partnership NHS Trust produced an A5 guide to tackling stress and mental health issues in the workplace.
**Personality disorder services**

An Adult Personality Disorder Strategy has been produced by partners working across Suffolk, headed by NHS Suffolk, Suffolk MIND and Suffolk Mental Health Partnership NHS Trust (SMHPT), with a multi-agency group to implement it.

The strategy aims to improve access and interventions to mainstream mental health services for people with personality disorder, as well as further developing local services designed for some of the more specific needs of people with personality disorder and their carers. The key aims are:

- to establish a core multi-disciplinary team of people who have developed skills and expertise in personality disorder
- to offer staff training and development
- to establish “personality disorder champions” within each community mental health and in-patient team
- to set up a network to provide support for service users and their carers
- to ensure that efficient, effective care is given to people with personality disorders.

There is also work at a regional level for specialist personality disorder services.

**Other issues**

Two projects have begun to investigate the best approach to supporting people with medically unexplained symptoms. These projects are using cognitive behaviour therapy or other psychological approaches to support people with chronic pain and people with gastro-intestinal symptoms. The aim is to reduce the level of physical investigations and treatments, and to help them develop ways of coping with their symptoms.
CHAPTER 3
Recommendations of the 2010 report

Recommendation 1
Many organisations in Suffolk have the potential to improve the social and physical environment of their local community. Healthy Ambitions Suffolk (HAS) and agencies with a responsibility for health improvement should develop plans to support this work by new approaches including; creating new ways to share and recognise best practice, supporting networks to implement new local wellbeing plans, and supporting innovation and evaluating its impact, so that new evidence can be generated to inform future initiatives.

Recommendation 2
Many communities have already made progress in improving health locally with the help of statutory, voluntary or commercial agencies. Agencies working with communities should consider how best to achieve long-lasting, community-owned change. This will involve identifying and maximising the major strengths and opportunities of each community, and investing in local people so that they can become community champions or facilitators.

Recommendation 3
Healthy Ambitions Suffolk and agencies with a responsibility for health improvement should consider how a community-based approach can address two intractable problems, reducing health inequalities and maximising mental wellbeing. This will need new approaches to improve the social and physical environment, and to empower communities to find locally-owned, culturally appropriate solutions.

Recommendation 4
Healthy Ambitions Suffolk and agencies with a responsibility for health improvement need to recognise that the health inequalities gap will not be closed by targeting the most deprived communities alone. Specific initiatives will also be needed for the wider community and to address rural health issues.

Recommendation 5
GP commissioning already delivers many clinical health improvement services, which address health behaviours such as smoking. With the advent of full GP commissioning, GPs will have greater freedom to work innovatively with communities to improve their health. NHS Suffolk and NHS Great Yarmouth and Waveney should work closely with GP commissioners to support their efforts to improve the long-term health of their communities, as well as continuing their support for clinical health improvement services.

Recommendation 6
The evidence that non-statutory agencies are often more successful than the NHS in delivering key health messages to communities, needs to be taken into account. Healthy Ambitions Suffolk and statutory agencies with a responsibility for health improvement need to find better ways to engage with the public so that health messages are appropriate, motivating and clearly understood.

Recommendation 7
Healthy Ambitions Suffolk, Greenest County, and agencies with a responsibility for health improvement need to strengthen their alliance, to influence areas which deliver both a sustainable environment and better health. More emphasis should be put on good urban and rural planning, good quality housing and improving opportunities for cycling, walking and outdoor exercise activity.

Work towards each recommendation should begin in 2011 and be monitored over the next five years as part of future public health reports.
Recommendation 8
Local employers have great potential to improve the health of their employees and improve the profitability of their businesses by decreasing sickness rates. An expansion of the HAS business awards scheme, which promotes health and mental wellbeing in the workplace by supporting local businesses, should be considered. Middle-aged, older and lower paid employees may particularly benefit from such schemes.

Recommendation 9
Reducing inequality early in life is particularly important in securing the future health of the Suffolk population. The Children’s Trust and Healthy Ambitions Suffolk need to consider how the health of children aged 0 to 2 years can be maximised.

Recommendation 10
There are specific groups who may have difficulty in accessing facilities and initiatives which aim to improve health, for reasons such as language, cultural belief or disability. Particular attention needs to be given to address the needs of these groups, for example, through outreach projects.
Suffolk is already a healthy county. Over the last decade, life expectancy has continued to increase gradually year on year, to an average of 79.4 years for men and 83.4 years for women. Nonetheless, there are still differences in life expectancy by geographical area and groups. There is a difference of 12 years between the electoral wards with the lowest and highest life expectancy in Suffolk. Since 2001-04 health inequalities in Suffolk have fallen slightly for men, but not for women.

For both men and women, the most important cause of health inequality, (measured by mortality rates) is cardiovascular disease (heart disease and stroke) with respiratory (lung) disease and cancer being other important causes for both sexes (see Figure 1). For women, the category labelled ‘other causes’, which covers a wide variety of conditions not included elsewhere, also accounts for a significant number of deaths.

Looking more closely at the trends in health inequality for coronary heart disease (CHD), it appears that here health inequalities have grown in Suffolk. In the period 1994-98 men aged under 75 living in the most deprived areas of Suffolk had an 18% higher risk of dying prematurely from CHD compared to the rest of the population. This risk increased to 40% in the period 2004-08. In 1994-98 women aged under 75 living in the most deprived areas had an 18% higher risk of dying prematurely from CHD compared to the rest of the population.

This risk increased to 70% in the period 2004-2008. A similar pattern is shown for men dying from stroke. Action is needed to reduce lifestyle risk factors for CHD, and improve uptake of medicines to control blood pressure and cholesterol in the most deprived areas of Suffolk, to reverse this trend.

While the urban areas, especially in Ipswich and Lowestoft, show the greatest concentrations of ill health, there are many people living in deprived circumstances in rural Suffolk. Deprivation in rural areas tends to be less concentrated than in urban neighbourhoods, which means it is more difficult to see (the so-called problem of hidden rural deprivation). It means geographic approaches to tackling problems risk biasing programmes in favour of urban areas where deprivation is more concentrated and visible. It is vital that all efforts to promote health in Suffolk must consider how they might influence the social causes of ill health, and the distribution of these determinants throughout the county.

### Learning from the literature

International and national literature suggests that individual health status is heavily influenced by people’s lifestyle choices; particularly whether people smoke, how much they exercise, whether they eat healthily and how much alcohol they drink. However, there is an increasing body of literature which suggests that these lifestyle choices are heavily linked to other social and economic factors e.g. whether individuals belong to social networks, the physical environment in which they live, their educational level, their employment status and local crime levels. These influences are known as the social determinants of health, as illustrated in Figure 2.

### What is the Marmot Review all about?

The Marmot Review considers the conditions in which we are born, grow up, live and work, and our age, as key factors not only in our length of life, but also in the amount of years we are able to live free from ill health.
or disability (the social determinants of health). The facts are stark. People who are living in poorer areas not only die sooner, but live more of their lives with a disability or in ill health.

The common factors that have an influence on our health are shown in Figure 3. This is because good health and wellbeing depend on a range of factors, such as decent housing, good education, a safe neighbourhood, strong local communities, social inclusion and meaningful employment. Often referred to as the social determinants of health, together they shape the fabric of our society and exert a strong control over people’s health. The social determinants of health influence people’s health both directly and indirectly.

Examples of direct effects include: more childhood infections without adequate heating and insulation; mental illness and loss of social functioning resulting from social isolation; and lower activity levels where there are fewer apparent recreation opportunities. Choices that individuals make can be indirectly affected by these determinants of health. In areas where the prevalence of smoking is very high and it may be viewed as the social norm, attempts at quitting smoking may be less successful. It is the accumulated effects of living in more adverse circumstances that give rise to the differences in lifespan.

The Marmot Review also explains that the relationship between social circumstances and health is graded, or on a sliding scale, meaning that social determinants are relevant to all our health outcomes. The more favourable they are, the more likely it is our health will be good; the worse they are, the more likely we will have a shorter lifespan and more years of disability. This is known as the social gradient.

In practice this means that focusing just on the most disadvantaged is not going to reduce health inequalities enough. There needs to be action for just about everyone, with a scale and intensity that is proportionate to the level of disadvantage. This includes strengthening the communities around individuals to allow them to achieve their ambitions for health.

The Marmot Review recommends six areas to concentrate on to reduce health inequalities, recognising that social determinants must be included in all local policies not just those relating to health:

- give every child the best start in life
- enable all children, young people and adults to maximise their capabilities, and have control over their lives
- create fair employment and good work for all
- ensure a healthy standard of living for all
- create and develop healthy and sustainable places and communities
- strengthen the role and impact of ill health prevention.

Much can be done to improve the lives and health of people at every stage of life, but as disadvantage begins before birth, a special emphasis is given in the review to explaining the importance of promoting children’s health and wellbeing. Disadvantage early in life is a strong predictor of economic, social, physical and mental health status in later life.

The full Marmot Review can be obtained from the following website: http://www.marmotreview.org

What do we know about the link between social determinants and health?

Social and community networks
Existing studies suggest that the strength of social and community networks is an important factor in the health of residents. Giving local people a sense of engagement and involvement in their community results in a greater sense of control (Marmot 2010) and of trust in the care, help and advice that they are given (Pearce and Davey Smith 2003). Data from the USA suggests that there is a connection between higher levels of community integration and trust, and lower mortality rates (Pearce and Davey Smith 2003).

Shaw (2004) suggests that the development of cultural activities, such as arts and entertainment, can contribute to building a strong sense of community. Another way of promoting social networks is to involve, fund and engage with voluntary and community organisations. These organisations may be more successful in communicating health messages and education than statutory bodies in a position of ‘authority’ (Solar and Irwin 2006).

Environment
The quality of the physical environment has long been understood to be an important influence on health. Safe, open spaces which provide the opportunity for exercise and relaxation in the fresh air are an important contributory factor in good health (Shaw 2004, Marmot 2010) and play a crucial role in reducing stress levels (IDeA 2009). In urban areas, or in new housing developments, it has become increasingly important to ensure that open spaces are made available for residents (Bambra and others 2010). Studies such as those by Shaw (2004) and by Krieger and others (2002) emphasise the importance of improving the environment in which people live if health improvements are to be made.

Green space can help to reduce health inequalities. A recent large-scale study in the UK of 336,348 patient records showed significantly less health...
inequality between rich and poor groups in areas with higher levels of green space than between similar groups in areas with less green space. The association between income deprivation and mortality differed significantly across the groups. There was 25% lower all-cause mortality in areas with high concentrations of green space compared to areas with low concentrations. For circulatory disease, there was a one-third (29.7%) lower mortality in greener areas compared to areas with low concentrations. For Faculty of Public Health 2010.

**Education**

Past studies suggest a link between educational attainment and good health. One reason for this may be that those with better qualifications will enter occupations with better pay and will therefore be able to afford a better standard of living, and will have fewer issues with access to healthcare, recreational facilities, good diet and so on (Wilensky and Satcher 2009). Another explanation may be that educational attainment is a reflection of socio-economic position and thus later in life, it is a reflection of the care and advantages afforded to children before they enter the education system (Low and others 2005).

Both the Marmot (2010) and IDeA (2009) reports stress the importance of good quality provision for children through early years education and in preschool provision. The IDeA (2009) report suggests that targeting preschool children and their families is of utmost importance, in order to inspire behaviour which prevents major health problems later in life.

**Employment**

Several reviews have noted the importance of having control over one’s work status, the nature of employment and the time spent at work for wellbeing and mental health. The greater the variety of tasks, opportunities for team working and autonomy the better the person’s health (Marmot 2010, IDeA 2009, Bambra and others 2010). A focus on stress reduction by employers can have benefits to the employing organisation in reducing absenteeism; the IDeA report (2009) states that the public sector has been particularly successful in targeting these concerns.

Socio-economic status has been
linked to health outcomes by a number of studies, suggesting that there is a link between securing minimum income standards and achieving a healthy population.

**Access to services**
The provision of health care services is clearly an important factor in the health and wellbeing of populations. However, past studies on the impact that social factors make on people’s health suggest that preventing ill health is particularly important and stress that this is not simply the task of the NHS, but of service providers working together (Marmot 2010, Wanless 2004).

**Housing**
Housing policy and public health has been the subject of many research projects. Recently, several of these papers have focused on the psychological aspects related to housing (Shaw 2004). A Canadian study showed that people who considered themselves to be suffering from emotional distress as the result of their physical environment, had a significantly higher risk of chronic health conditions (Wilson and others 2004). Many papers point out that housing is not simply about provision of shelter but that it also reflects a sense of control about one’s life and one’s living space (Shaw 2004 is especially clear). Insecurity of tenure or high cost of housing (whether rent or mortgage) raises stress levels and feelings of insecurity, and can impact on the physical and mental health of children and adults (Wilson and others 2004).

In the UK, Stewart (2005) points out that housing policy and social housing practitioners are key contributors to public health, and that social housing should always be considered as part of public health interventions. Similarly, the National Institute for Clinical Excellence (NICE) drew up its own set of recommendations in 2008 to be adopted by local authorities and planners, in order to promote physical activity within the built environment.

**Crime**
Specific references to links between crime and public health are limited in the literature reviewed for this project. There is evidence to suggest that increased social inclusion can result in lower levels of crime, and in turn this results in lower levels of stress, and consequent improvements in the wellbeing of the population (Marmot 2010, IDeA 2009). The links between crime and mental health have also been established (IDeA 2009), suggesting that reducing crime levels is another way in which the health of populations can be improved.

**Transport**
The relationship between access to a private car and health is somewhat complicated. From one point of view car ownership is linked to better health, partly as it indicates higher socio-economic status and partly as it makes for better access to health facilities (Macintyre and others 2001). Another view suggests that poorer communities may be more likely to undertake healthy behaviours, such as walking and cycling, albeit through necessity rather than choice (Regidor 2006, Blouin and others 2009, Baum 2005).

**What is the role of local government in improving health?**
From the eradication of disease, to the building of sewers and the regulation of working conditions, local authorities and councils in England have a long history of public health actions that have directly improved and protected people’s health. Prior to 1974, this work was undertaken jointly with directors of public health working in local government.
The importance of local government’s role in health was recognised in the Marmot Review in the following way: “…local councils have the power to secure the economic, environmental and social wellbeing of the local population. They are therefore in a key position to mobilise action to tackle health inequalities and improve wellbeing.” Local authorities have a major role as community leaders, providers of services and in commissioning services from other organisations.

Many of the services currently provided by local authorities impact on health, because health problems are often complex with inter-related causes. For example, the causes of obesity are the result of low physical activity levels and high calorie diets. Solutions to the growing obesity epidemic are complex, but include changing the built environment to influence activity levels, strengthening community networks as well as providing support and information to individuals to improve their diet.

One example of this community led approach is the Reach Out programme in parts of Ipswich, Haverhill, Sudbury and Brandon.

NHS Suffolk has asked communities to Reach Out to tackle obesity

Reach Out aims to tackle obesity through highlighting problems which prevent local communities from adopting a healthy lifestyle, and finding new ways in which they can be overcome. It will specifically tackle obesity through both primary prevention, e.g. improve breastfeeding rates and nutrition in the early years, and secondary prevention, such as enabling communities to effect changes in their physical and social environments. Volunteers have been asked to give their views on the issues affecting their local community and share ideas on new initiatives which could help. Following the successful pilot year, this project will continue to be supported by NHS Suffolk.

The Reach Out project is being run by NHS Suffolk in conjunction with numerous health, council, leisure, third sector and voluntary partners in the Suffolk communities of Brandon, Sudbury, Haverhill and Ipswich.
How is Suffolk tackling the social determinants of health?

Local government, business and voluntary agencies routinely improve the fabric of Suffolk society as part of their day to day work, which has had a major positive impact on the health of the Suffolk population.

To support this work, Healthy Ambitions Suffolk was set up in 2008 as our county-wide vision to make Suffolk the healthiest county by 2028, with a particular focus on tackling health inequality. All of the leading public services, and many voluntary sector organisations and businesses, have committed to this initiative to tackle the broader social determinants of health. The work programme for Healthy Ambitions Suffolk is now quite extensive, much of it based around local communities.

Healthy Ambitions Suffolk

This ambitious partnership project is about making Suffolk the healthiest county in the UK. It means taking action early to prevent health problems.

Some parts of the county experience a 12 year age gap in life expectancy – a gap that Healthy Ambitions Suffolk aims to close.

It is inspiring all sorts of people to get active and choose healthier lifestyles.

Healthy Ambitions Suffolk is encouraging people - councils, NHS, businesses, voluntary organisations, schools, youth groups and individuals - to work together to improve their own and others lives.

http://www.healthyambitionssuffolk.nhs.uk
References

- IDeA: Improvement and Development Agency (2009) Valuing Health: Developing a business case for health improvement
- Faculty of Public Health (2010) Great outdoors: how our natural health service uses green space to improve wellbeing: an action report. London, Faculty of Public Health
In this study we looked at the social determinants of the health and wellbeing of residents of Mid Suffolk using a combination of information from other reports, data on the health of the district, interviews with community groups and other organisations, the views of residents gathered in visits and through an online survey. This allowed us to build up a picture of health and wellbeing in the area, and to understand what can be done to support people in leading healthier lives.

Social and community networks

Several of the people interviewed commented on the strength of community networks in Mid Suffolk. One interviewee said that many residents have a strong sense of identity and connection to the village or town in which they live. Residents are supported in achieving positive outcomes for their community by a network of voluntary and community organisations, covering a diverse range of interests from horticulture to history, scouts and guides, to walking groups. These groups are supported by a strong council for voluntary services, Mid Suffolk Action in Partnership, which provides advice and training for community groups.

The development of the Mid Suffolk community strategy is a crucial part of ensuring that the needs of local people are taken into account in planning service delivery and the allocation of funding. Community Board pilots were run in three areas. These pilots sought to give local people a greater say in the allocation of funds in their area, and in determining what the priority areas of action should be. The willingness of people in the pilot study areas to be involved and to attend the budget allocation meetings, illustrates the strength of community identity.

Several of the groups visited for this study engage in activities which promote a sense of community and help to build social networks. The Debenham LEAP Centre makes its facilities available to the community outside of its formal courses; the Rural Coffee Caravan visits local villages and encourages neighbourly feelings with support mechanisms and the provision of information; Stowmarket Opportunities Group provides practical and emotional support to parents, one user commenting that its primary benefit is in developing a sense of shared experience, that “everyone’s in the same boat.”

These groups are also good at signposting users to the services of other organisations, and in suggesting sources of advice and guidance. While Home-Start Mid Suffolk work with families on a one-to-one basis, staff are able to signpost their clients to other community groups or to the public sector as necessary. Organisations like the Rural Coffee Caravan and Stowmarket Opportunities Group also play an important role in signposting users to specialist help when appropriate. These signposting activities have been successful because of the trust that is built up between the groups and their users.

The development of strong social networks is not the exclusive responsibility of voluntary and community groups. The West Suffolk Community Safety Partnership has also been involved in activities to improve community cohesion including the development of Community Orchards and a Mediation Scheme for repeat offenders. Mid Suffolk District Council (MSDC) works closely with parish and town councils to provide grant and capital aid to community groups, to involve local people in decision making and to stand up for local people, and to hold other agencies to account as appropriate.
The results of the national Place Survey and relatively high voter turnout in district elections are both suggestive of good engagement between MSDC and communities.

One resident sums up how living in a village in Mid Suffolk contributes to his sense of wellbeing: “We also have an advantage of living in a friendly, active village with a good community spirit, and a village hall and events run and promoted by a good committee… Overall, we live in a place where we would want to live, and that itself makes one feel good!”

>> Home-Start Mid Suffolk provides support to families in need through a network of volunteers that offers advice and friendship. Families are supported through a wide range of challenges including mental illness, disability, family breakdown and bereavement.

>> Rural Coffee Caravan Information Project was launched in 2003 to provide access to information for rural residents. It visits villages once a month and provides an opportunity for residents to chat with each other and with volunteers. The regular visits provide an opportunity for the project team to build up trust with residents, and have meant that the project has been particularly successful in supporting some of the most rural villages.

>> Stowmarket and Area Opportunities Group is a charity providing a range of activities for children with additional needs. Children generally take part in supervised free play, giving parents an opportunity for short respite in the kitchen area where they have a chance to chat with those in similar circumstances. The group’s primary benefit is in providing support and respite for parents, supporting their health and particularly, their mental wellbeing.

Environment

Interviewees and residents of the district were unanimous in pointing out the beauty of Mid Suffolk’s rural environment. A lack of large urban centres contributes to good air quality, while the rural environment offers plenty of opportunities for residents to take part in health-promoting, outdoor activities – walking, cycling, gardening and so on.

One resident pointed out that “things that are good are also things that are bad.” Living in the country offers residents access to peace and quiet and opportunities for being active, yet it can also be isolating. At most risk are very small villages without any local amenities such as bus routes, shop, village hall, post office or public house. Activities and groups running in Mid Suffolk make a real effort to reduce such negative aspects of living in very rural or remote areas. Projects such as Extended Schools and the LEAP centres are helping to open up access to facilities in schools and learning centres.

The Rural Coffee Caravan encourages the development of community spirit or neighbourliness which lasts beyond its visits; providing a support network for local people to act as sources of mutual support. Many families to whom Home-Start Mid Suffolk provides support are facing issues of isolation. One of their users commented that “it’s been great to have a friendly face visiting each week…I feel able to cope at home and look forward to getting a visit.”

Most residents responding to the online survey agreed that the natural environment in Mid Suffolk makes it an attractive and healthy place to live. One wrote: “There is plenty of access to the surrounding countryside and the area is not as populated or congested as some areas, both
giving the feeling that it is a nice place to live and also a safe place to live.” Another noted that: “Being out in the countryside helps to reduce work stress.”

The range of activities that being in the countryside opens up encourages physical activity as well as opportunities to relax. One person said: “The opportunity to indulge in plenty of outdoor activities, such as gardening, good access to the local rights of way network for dog-walking and leisure walking, bird watching and nature study, exploring local history… The above activities as well as being physically beneficial, involve me in positive social interaction with my neighbours.”

**Education**

At Key Stage 2, primary school children in Mid Suffolk perform better than those across Suffolk. However, GCSE results in the district suggest that performance is slightly below the county average. GCSE results are improving, with a significant rise in achievement between 2001 and 2009. For the full district profile, visit [www.suffolk.nhs.uk](http://www.suffolk.nhs.uk).

The proportion of Mid Suffolk residents with no qualifications is broadly inline with that of Suffolk, but higher than the average in the East of England. With an economy moving towards jobs that require higher-level skills this may present a problem for the district. Addressing this skills gap is critical for ensuring the employability of Mid Suffolk residents and for attracting businesses into the area.

Several of the organisations spoken to are making efforts to help residents of Mid Suffolk improve their skills levels. The Extended Schools project is helping to open up school facilities to families and to involve parents in the education of their children. Evidence suggests that as parents become more involved in their child’s education, the pupil’s achievement improves. The same project is also putting on specialist education sessions in sexual health and in smoking cessation. In its first few months, Debenham LEAP Centre ran a series of successful IT courses, family learning courses - particularly Hearing Children Read - and leisure learning courses. The centre also has examples of learners getting
Those working outside the district have wages which are, on average, 10% higher than those in Mid Suffolk.
opportunities. Extended Schools also provides high quality childcare after school and in holidays, allowing parents the chance to work without having to cut short hours to pick children up from school. In a rural area such as Mid Suffolk this sort of facility is particularly important, given travel times. In one of our interviews, it was noted that families with lower income levels are less able to pay for children to participate in activities, which may lead to reduced opportunities for socialisation.

Mid Suffolk also has a fairly high proportion of people working at home: the Mid Suffolk Core Strategy suggests that 13% are home-workers, rising to 20% in some villages. Opportunities for flexible working patterns, including working from home, can offer some people the chance to work when they may otherwise be unable to do so. The provision of broadband services is increasingly likely to be a requirement for home workers, as well as being crucial for access to information and communication for all residents.

Mid Suffolk does have problems with securing high-speed, affordable internet access, although these are by no means limited to this Suffolk district. This will limit the growth of working at home as a solution to transport issues.

Mid Suffolk has an economy which has historically been dominated by low wages for those working within the district and higher wages for those commuting outside the district. As the economic profile of the district changes, this disparity should reduce as wage levels in the district increase. Other studies suggest that this should have a positive effect on health and wellbeing of Mid Suffolk residents.

Lifestyle

The profile of Mid Suffolk on page 68 provides detailed information about the lifestyles of people in the district. This shows that levels of smoking and alcohol misuse are not significantly different in Mid Suffolk from the rest of the county, and that while participation in exercise was lower amongst children in Mid Suffolk than across Suffolk as a whole, the prevalence of obesity amongst year six students was significantly lower. The rural environment and the opportunities that it affords for informal exercise may well be a contributing factor, and help to explain why Mid Suffolk performs relatively poorly in the Health Poverty Index for access to recreational facilities (page 71). A further explanation for Mid Suffolk’s relatively poor score is because national indicators only measure those facilities run by the council. Stowmarket Leisure Centre is one of the most attended wet/dry facilities in Suffolk, with programmes very much directed to healthy opportunities. Mid Suffolk Leisure Centre has over 650,000 visits per annum and has been nominated in 2010 as one of the five best leisure centres in the country by the Fitness for Industry Association. The other Mid Suffolk facility is Mid Suffolk Leisure Centre has over 650,000 visits per annum and has been nominated in 2010 as one of the five best leisure centres in the country by the Fitness for Industry Association.
Mid Suffolk does not have urban parks but it does have plentiful access to managed countryside sites.

In visits to community groups in the district, there were examples of ways in which the strong sense of community in Mid Suffolk was contributing to good health. Some examples are seemingly small, such as the provision of rubber feet for walking sticks by the Rural Coffee Caravan team, helping to prevent falls. Other examples are much more fundamental contributions to good physical and mental health: the community support for families and children with additional needs by the Stowmarket Opportunities Group, and support for isolated families, particularly with problems such as post-natal depression by Home-Start Mid Suffolk. The Museum of East Anglian Life also runs a number of activities which promote wellbeing, in partnership with the Suffolk Mental Health Partnership NHS Trust.

In response to the online survey, a number of residents commented on the availability of fresh food and produce in the district. In addition, space allows residents to grow their own produce. “As a family we grow most of our vegetables and keep chickens for fresh, free range eggs,” said one resident. Residents’ wellbeing is also promoted through opportunities to participate in healthy behaviours. One resident said: “There are lots of opportunities to be outdoors in fresh air. There is walking and golf and the ground is sufficiently flat to encourage cycling as a pastime.”

Housing

The cost of private housing in Mid Suffolk is expensive at around 14% higher than across Suffolk as a whole. The district has lower wage levels, making housing even less affordable. The ratio of house prices to average wages in Mid Suffolk was 8.78 in the 3rd quarter of 2009. Across Suffolk as a whole it was 6.98. Unlike other parts of the county however, house prices have not been driven up by the purchase of second homes in villages.

There have been a number of community initiatives to promote healthy lifestyles, such as working with Ipswich Town Football Club to offer incentives for smoking cessation.
New building developments are one way to ease the supply of private homes at affordable prices. While the current economic climate has inevitably led to a slowdown in construction, the district is also constrained by planning legislation. Settlement hierarchies imposed as part of the Local Development Framework process have restricted the council’s ability to control developments. In rural areas, and in most small villages in the district, this means that there is an assumption against the construction of new homes. While there is an acknowledged need to maintain the rurality of the district and to protect its environment, this has impacted on rural communities. Some of our interviewees commented that the availability and affordability of housing in these communities can mean that families (and therefore support networks) may be split up, because opportunities to purchase suitable housing in these areas are often limited. The same is true of older people living in rural areas. A lack of suitably adapted housing can mean that they are forced to move away from areas in which they have friends, family and social networks.

Mid Suffolk has some issues with access to affordable housing. One individual had significant issues with access to suitable accommodation. The only option was a move from Stowmarket to Ipswich which would have taken the household away from family support, friends and schools. Although only one case, this certainly illustrated the stress caused by concerns over housing that Wilson and others (2004) and Stewart (2005) identified in their work. In new developments, MSDC seeks up to 33% affordable housing in order to increase the availability and reduce issues around allocation. The recent economic climate has required the council to take an economically pragmatic view of demands for affordable housing in developments, especially where it threatens the viability of the development. In other cases, MSDC has been flexible and secured additional community facilities such as open space and community centres in lieu of more affordable homes. MSDC has also made significant efforts to ensure the quality of both affordable and private housing. A number of studies have shown the impact of environmental health in the home including the impact of lead piping, the prevalence of accidents in the home and fire safety (Shaw 2004, Marmot 2010).

MSDC provides help for the improvement of living conditions, and has grant money available to help with energy efficiency and fuel poverty. The district council has also been able to work in partnership to provide funding for ‘Safe and Secure’ funds to enable home security improvements for priority groups.
The Gypsy and Traveller community are recognised by MSDC as being the largest minority ethnic group in the district, and the Council is making efforts to provide suitable facilities for them...

**Transport**

In a rural district such as Mid Suffolk, transport issues are critical because they determine the ease with which residents are able to access vital services. These may be health care services or they may be services which impact on health less directly: opportunities for education, employment or to access social support networks. Without a car, many areas of Mid Suffolk are hard to access and residents become reliant on public transport systems which are “reasonable but not optimal”. One resident described bus services as “Good, especially for the over 60s!” although others commented on the difficulties of relying on a bus for getting to work from a rural location. The importance of transport is highlighted by data which suggests that 60% of the population in Mid Suffolk live in an area which has amongst the worst access to services (eg distance to travel to GP practice, school, post office etc) in the country.

The issues caused by the rural nature of the district were recognised by several of those that we interviewed. Transport issues are a major factor to feelings of isolation that can affect residents. In turn, isolation can be exacerbated by problems with accessing health services, including mental health services, out of hours GP services and physiotherapy. These are starting to be addressed by schemes, such as Improving Access to Psychological Therapies run by Suffolk Mental Health Partnership NHS Trust. MSDC is also making efforts to improve the availability of on-demand transport services, such as community buses.

A further area in which councils can make a difference is in promoting healthy lifestyle choices. Streets and traffic flows can be managed in order to make it easier and safer to cycle and walk (Marmot 2010). One resident commented in the online survey: “Better cycle paths would allow more cycling, the current cycle paths are not always on the routes people want them to be.” Another resident commented that she would like to be able to walk her child to school but could not as the road was busy and too dangerous. A footpath would enable her to walk the short distance in safety. Many of the groups that are supported by Mid Suffolk Action in Partnership, or who were consulted in this project, specifically aim to address issues relating to rural isolation caused by transport issues. The Rural Coffee Caravan is a good example of this. The Village Visits is another good example of a project which seeks out potentially vulnerable people and provides help. The more rural the area the more significant the transport difficulties and the more important it is that access to services is addressed. This problem has been exacerbated as local services close (post offices, village shops and so on). For one Home-Start Mid Suffolk user, the opportunity to have a volunteer come and visit regularly was important: “My family do not live nearby and I felt isolated at home so it has been great to have a friendly face visiting each week.”

MSDC is also making efforts to improve the availability of on-demand transport services, such as community buses.
Other projects, such as the Debenham LEAP Centre, reduce the need for residents of rural areas to travel to major centres such as Stowmarket, Bury St Edmunds or Ipswich to access learning opportunities. This centre also brings access to IT facilities into the community. The Aims project has similar goals. This project brings services into rural communities on a bus and can provide dispensing services, well baby checks and provide information and advice. On Friday and Saturday nights the bus provides SOS services for young people.

For those wanting to travel further, the district is well served by transport links which allow travel outside the district by major road arteries, by rail or by bus services, to employment centres in Bury St Edmunds, Ipswich, Norwich and London.

In a rural district, people inevitably rely on private transport. While most villages will have some sort of bus route there is no way that it can satisfy the transport needs of every resident. Those residents without access to their own transport can feel isolated, but there are a number of schemes running which seek to bring services closer to rural communities. Other creative solutions include the growth of on-demand transport, such as community buses.

Crime

Levels of crime in Mid Suffolk are objectively low, and also low in comparison to other areas of the county. Figures for total crimes are lower in Mid Suffolk than in other rural districts of the county at 3.3 crimes per 1,000 people, compared with Babergh and Suffolk Coastal (both 4 per 1,000) and Forest Heath (6.5 per 1,000). Despite low levels of crime there is a feeling that the fear of crime is still significant. The studies reported earlier suggest that this may have an impact on wellbeing even though actual crime levels are low. Making people feel safer is therefore a priority in promoting wellbeing. The strength of the partnership between MSDC and the Western Suffolk Safer Neighbourhood Team, in part a result of the co-location of teams in the MSDC offices, has seen a number of joint initiatives to address concerns about community safety and anti-social behaviour. This includes specific funds to help secure homes and maintaining a pot of money which can be used to help families under threat of domestic violence. Another good example of partnerships in Mid Suffolk working to make communities feel safer is in the redevelopment of the Barham picnic site.

Previously an area noted for anti-social behaviour, the site was improved through collaborative efforts of a number of organisations including MSDC, Suffolk County Council and the Safer Neighbourhood Team. The community has since been encouraged and helped to apply for funding to continue the improvement of this site and to build a new Green Gym.
Needham Market Internet Café, which operates every weekday evening, has made a significant contribution in reducing perceptions of anti-social behaviour by providing a safe place for young people to meet and to spend time. The result has been fewer potentially intimidating groups of young people hanging about the town. The café is also valuable as it provides an opportunity for young people to meet and socialise and to interact with other members of the community that are acting as volunteers.

While the district has low crime levels, these are maintained through strong partnerships between the district council and Safer Neighbourhood Team and through empowering local communities to affect changes which reduce anti-social behaviour through the provision of community facilities.

>> Needham Market Internet Café opened in September 2007 and opens six days a week. The centre is open to all. It is mostly used by younger people as a safe place to gather after school and during the evenings. The focus of the café is on providing a safe recreational space, rather than education, and has been particularly successful in reducing the perceived level of anti-social behaviour in Needham Market.

Conclusions

Mid Suffolk has strengths which contribute to the quality of life in the area, and to the health and wellbeing of its residents.

Strong communities – there are a number of examples in which residents work together and provide support to one another. Mid Suffolk has a significant number of strong voluntary and community organisations, and even outside these groups residents are frequently willing to provide help to their neighbours. In a very rural district with the persistent threat of isolation, this support is crucial in helping to overcome issues such as access to services or information, or difficulties with transport.

Natural environment – Mid Suffolk benefits from being an attractive rural area with a low population density, offering its residents a healthy place to live. Many of those consulted commented on the benefits that this environment offers, in terms of being stress-reducing and promoting healthy behaviours, including cycling, walking and the chance to be involved in other outdoor activities.

Strong delivery partnerships – Strong partnerships between public sector organisations and between the public and third sectors enable effective collaborative working. The co-location of the district council and Safer Neighbourhood Team is a good example, which has benefited the district by enabling these organisations to work closely together to deliver added value to communities.
Community orchards: These are spaces where volunteers come together to plant and look after fruit trees, often traditional varieties, and then share the produce. They provide opportunities to work together, to develop new skills, look after heritage varieties and benefit from home-grown fruit.

Elementary occupations: This consists of simple and routine tasks which mainly require the use of hand-held tools and often some physical effort.

Extended schools: Working with the local authority, local providers and each other, schools offer extended services. There is a varied menu of activities, including study support, play/recreation, sport, music, arts and crafts and other special interest clubs, volunteering and business and enterprise activities, for primary and secondary schools; childcare 8am – 6pm, 48 weeks a year for primary schools; parenting support, including family learning; swift and easy access to targeted and specialist services such as speech and language therapy; community access to facilities including adult learning, ICT and sports facilities.

Home Start: Through a UK network of nearly 16,000 trained parent volunteers Home Start support thousands of parents who are struggling to cope. Families need support for many reasons including post-natal illness, disability, bereavement, the illness of a parent or child or social isolation. Parents support other parents - to help build a family’s confidence and ability to cope. For more information visit www.home-start.org.uk

Improving Access to Psychological Therapies (IAPT): IAPT (or “talking therapies”), is about intervening early to maintain and improve the quality of people’s lives and to stop the disabling effects of their mental health problems.

LEAP centre: The LEAP Project was formed in 2007 by University Campus Suffolk (UCS), Suffolk Learning and Skills Council, Suffolk County Council and the East of England Development Agency. The aim of LEAP is to make access to education and skills as local as possible in response to the rural nature of the county and recognising the problems of transport to education provision. The LEAP Project is unique to Suffolk and has centres and points across the county.

Local Development Framework: Every district has a Local Development Framework, which is a collection of development documents that outline how planning will be managed in an area.

Mid Suffolk Core Strategy: This sets out the vision and strategic planning objectives for the development of the district. It is part of the Development Plan for the district, and is one of the documents that makes up Mid Suffolk’s Local Development Framework.

Safer Neighbourhood Team: In Suffolk, Safer Neighbourhood Teams are made up of police officers, community support officers, ‘specials’ and support volunteers. These teams work alongside staff from other organisations, including district and borough councils, to provide an even better service to local people across the county.

Settlement hierarchies: Settlements (such as groups of houses) are grouped and classified according to their size and shape, and the result is a settlement hierarchy. The size of the settlement and the distance between similar sized settlements increases the higher up the hierarchy.

Social housing: This is housing let at low rents and on a secure basis to people in housing need. It is generally provided by councils and not-for-profit organisations such as housing associations.

Each team has a remit to solve problems identified by local people – which could range from crime and anti-social behaviour, to noise and litter.
A workshop was held on 3 February 2010 with local elected politicians across Suffolk, to discuss and identify ways for promoting physical activity, healthy eating, mental health and community wellbeing, based on experiences in Suffolk.

The workshop delegates highlighted the following as areas of high priority:

- Policies to change urban design, to decrease car use and increase active transport; access to bicycles and measures to address bicycle traffic, including cycle paths
- Support for adult and child carers, including respite arrangements
- Expand services offered through libraries; use libraries as a portal for advertising volunteering schemes in Suffolk, and as comprehensive community resource centres (using Gainsborough as an example), form library groups with special interests, book and internet-based guided self help, and provide access to educational/skills courses offered at either discounted rates or free
- Counselling for families on matters like domestic violence, mental health, and financial hardship
- Chair-based exercises in residential/nursing homes as well as in people’s own homes
- Promoting walking, cycling and public transport to and from school. Provision of open spaces for play, improve access to activity facilities for toddlers and young children, extend sports and other physical activity (PE) in schools, including access to sport and play facilities outside of school hours, and improve physical activity standards in child care. Include community activity co-ordinators to organise after-school and vacation exercise activities
- Ideas to improve quality of food consumed by children; lunchbox bans for unhealthy food, clearer information on diet (eg. 5 juice boxes are not equivalent to 5 portions of fruit and vegetables a day), and nutritional counselling for parents
- Empower the child as a “family health coach lead”, in charge of reaching pre-set goals
- Methods to improve mental health; provide mental health updates for school nurses to identify at risk students, mental health awareness courses for school staff, mental health training for all health trainers. Access to one-stop shop where young people can access a range of services under one roof, including advice on drugs, alcohol, bullying, sexual health, and relationships
- Improve nutritional standards for infants in care.
A further workshop was held on 9 June facilitated by IDeA, to discuss the preliminary findings of the Annual Public Health Report, the Marmot Review and the Mid Suffolk case study prepared by University Campus Suffolk and presented on page 17. This workshop involved colleagues from across the county, including parish, town and district level representatives and the voluntary sector. The discussions focused on what can make a difference in communities and how people become inspired to make lifestyle changes. Some of the challenges encountered in translating broad strategic objectives into local delivery, and sustaining projects, were highlighted as areas for attention. Access to services, particularly in rural areas and the wider engagement of increased numbers of individuals in local opportunities were areas identified for further work.

The following issues were seen as important in tackling the social determinants of health in Suffolk; enabling communities to find solutions and acknowledging the importance of everyday activities in promoting health; learning from good practice across the Suffolk community, securing funding for future initiatives, developing strong partnership working focusing on health inequality, recognising needs in rural areas, amongst ethnic groups and the younger and older generations.

“...enabling communities to find solutions and acknowledging the importance of everyday activities in promoting health; learning from good practice across the Suffolk community,...”
### Suffolk’s health at a glance

<table>
<thead>
<tr>
<th>Suffolk</th>
<th>Babergh</th>
<th>Forest Heath</th>
<th>Ipswich</th>
<th>Mid Suffolk</th>
<th>St Edmundsbury</th>
<th>Suffolk Coastal</th>
<th>Waveney</th>
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<tbody>
<tr>
<td><strong>Life expectancy 2006/08</strong></td>
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<td><strong>Life expectancy gap between the most deprived and least deprived areas (2003-07)</strong></td>
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<tr>
<td>Male</td>
<td>M: 5.7yrs</td>
<td>M: 0.3yrs</td>
<td>M: 3.4yrs</td>
<td>M: 3.2yrs</td>
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<td>M: 3.9yrs</td>
<td>M: 9.6yrs</td>
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<td>Female</td>
<td>F: 4.5yrs</td>
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### Health improvements needed

| **Main causes of death** | | | | | | | |
| Cancer, CVD, lung disease 75.2% of deaths between 2006/08 | Cancer, CVD, lung disease 77.7% of deaths between 2006/08 | Cancer, CVD, lung disease 76.2% of deaths between 2006/08 | Cancer, CVD, lung disease 77.2% of deaths between 2006/08 | Cancer, CVD, lung disease 75.4% of deaths between 2006/08 | Cancer, CVD, lung disease 74.1% of deaths between 2006/08 | Cancer, CVD, lung disease 74.1% of deaths between 2006/08 |
| **Potential improvement areas (Health Poverty Index)** | | | | | | | |
| Health capital, health care resourcing, access to social care, access to secondary care, local government resourcing | Health care resourcing, access to social care, human capital, wealth, social capital, preventative health resourcing | Change in job supply, income, wealth, human capital, lifestyle, home environments, work & local environments, access to social care and psychological morbidity | Recreational facilities, health care resourcing, access to social care | Preventative care resourcing, recreation facilities, access to social care, lifestyle, health care resourcing and health capital | Change in job supply, income, wealth, human capital, recreation facilities, access to social care, lifestyle, health care resourcing | Preventative care resourcing, recreation facilities, access to social care, lifestyle, health care resourcing and health capital | |

1 Health capital measures the potential for health across life. Poor scores may reflect a high percentage of middle age and elderly people.
2 May be the effect of not taking full account in the Health Poverty Index, of services provided to the population of US service personnel in Forest Heath.
3 The Place Survey/Health Poverty Index do not necessarily offer a comprehensive assessment of an area or recognise recent developments or improvements.
### Suffolk’s health at a glance

#### Potential improvement areas (Place Survey)³

<table>
<thead>
<tr>
<th>Area</th>
<th>Activities for teenagers, public transport, affordable housing, health services, level of crime</th>
</tr>
</thead>
</table>
| Babergh       | Health Services  
| Forest Heath  | Activities for teenagers, level of traffic congestion, public transport, affordable housing, level of crime |
| Ipswich       | Activities for teenagers, congestion, road and pavement repairs, level of crime, clean streets |
| Mid Suffolk   | Activities for teenagers, public transport, affordable housing, health services, level of crime |
| St Edmundsbury| Activities for teenagers, level of crime, health services  
| Suffolk Coastal| Activities for teenagers, job prospects, traffic congestion, level of crime, health services |

#### How many live in deprived areas

<table>
<thead>
<tr>
<th>Area</th>
<th>0% most deprived fifth in England</th>
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<td>Babergh</td>
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<td>Forest Heath</td>
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<td>Ipswich</td>
<td>24% most deprived fifth in England</td>
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<tr>
<td>Mid Suffolk</td>
<td>0% most deprived fifth in England</td>
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<tr>
<td>St Edmundsbury</td>
<td>0% most deprived fifth in England</td>
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<tr>
<td>Suffolk Coastal</td>
<td>0% most deprived fifth in England</td>
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</tbody>
</table>

#### Projections for common diseases 2010-2020

| Area          | CVD 7.2% in 2010 to 8.3% in 2020  
|---------------|-----------------------------------|
| Babergh       | CHD 5.9% - 6.7%  
| Forest Heath  | Stroke 2.8% - 3.2%  
| Ipswich       | High blood pressure 26.4% - 28.2% |
| Mid Suffolk   | COPD 2.6% - 2.7%  
| St Edmundsbury| Diabetes 4.1% - 5.3%  
| Suffolk Coastal|                                |

#### Exercise

| Area          | 93.3% of children have two hours of PE a week  
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<tbody>
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<td>Forest Heath</td>
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<tr>
<td>Ipswich</td>
<td>89.1% of children have two hours of PE a week</td>
</tr>
<tr>
<td>Mid Suffolk</td>
<td>87.3% of children have two hours of PE a week</td>
</tr>
<tr>
<td>St Edmundsbury</td>
<td>94.3% of children have two hours of PE a week</td>
</tr>
<tr>
<td>Suffolk Coastal</td>
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#### Healthy eating

| Area          | 41.4% in 2008/09 ate 5 a day 5-7 days a week  
|---------------|-------------------------------------------------|
| Babergh       | 7.1% ate 5-a-day less than one day a week  
| Forest Heath  | 44.7% in 2008/09 ate 5 a day 5-7 days a week  
| Ipswich       | 11.1% ate 5-a-day less than one day a week  
| Mid Suffolk   | 40.2% in 2008/09 ate 5 a day 5-7 days a week  
| St Edmundsbury| 15.2% ate 5-a-day less than one day a week  
| Suffolk Coastal|                                  |

### Projections for common diseases 2010-2020 (Diabetes 2010-2025)

| Area          | CVD 6.8% in 2010 to 7.9% in 2020  
|---------------|-----------------------------------|
| Babergh       | CHD 5.6% - 6.5%  
| Forest Heath  | Stroke 2.6% - 3.1%  
| Ipswich       | High blood pressure 30.6% - 33.2% |
| Mid Suffolk   | COPD 2.7% - 3%  
| St Edmundsbury| Diabetes 4.8% - 6.4%  
| Suffolk Coastal|                                |

#### Exercise

| Area          | 94.3% of children have two hours of PE a week  
<table>
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<td>Babergh</td>
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<td>Suffolk Coastal</td>
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</table>

#### Healthy eating

| Area          | 45.4% in 2008/09 ate 5 a day 5-7 days a week  
|---------------|-------------------------------------------------|
| Babergh       | 12.3% ate 5-a-day less than one day a week  
| Forest Heath  | 14.5% ate 5-a-day less than one day a week  
| Ipswich       | 15.2% ate 5-a-day less than one day a week  
| Mid Suffolk   | 15.2% ate 5-a-day less than one day a week  
| St Edmundsbury| 15.2% ate 5-a-day less than one day a week  
| Suffolk Coastal|                                  |

³ The Place Survey/Health Poverty Index do not necessarily offer a comprehensive assessment of an area or recognise recent developments or improvements.
Health trainers with local schoolchildren on the HAS bus. Age-enhancing software is used to demonstrate the effects on ageing of health behaviours, such as smoking, diet and exercise.
CHAPTER 8

District and borough health profiles

Health profiles have been produced jointly between the NHS, county, borough and district councils, as there was a widely recognised need for information at locality level in order to inform local plans for health improvement. The profiles included here give an overview; a more detailed profile, including further information on the wider determinants of health, data sources and explanatory notes are available on the internet at www.suffolk.nhs.uk.

Sources used include:
- Disease projections – coronary heart disease, chronic obstructive pulmonary disease, cerebrovascular disease, stroke, hypertension: Eastern Region Public Health Observatory (ERPHO) (2008), Modelled prevalence estimates (aged 16+), Version 1.0.
- Deprivation: Eastern Region Public Health Observatory (ERPHO) (2009), Health Profile 2009.
If 100 people lived in Babergh, then:

23 would be children (0 to 18 years) and 77 would be adults (19 years and above)
Nobody would live in the most deprived areas where their health may be worse
8% of children aged 4 to 5 years and 13% of children aged 10 to 11 years would be overweight or obese
6 people aged 16 years and over would have coronary heart disease
3 people aged 16 years and over would have lung disease
51 people aged 16 years and over would take enough exercise
41 people aged 16 years and over would eat enough fruit and vegetables
22 people aged 16 years and over would smoke
24 people aged 16 years and over would drink too much alcohol

How long do people live and what is the potential for better health?

In 2006-08 it was estimated that men live to about 79 years old and women to 84 years, which is in line with the county as a whole and with England and Wales.

In 2003-07 the difference in life expectancy for men living in the most deprived parts of Babergh compared to those living in the most affluent parts of the district was 5.7 years. For women this gap in life expectancy was 4.5 years.
Reducing mortality from coronary heart disease, stroke and other cardiovascular disease in both sexes, in the most deprived fifth of the population would achieve the greatest gains. In the same group, fewer accidents and suicides in men, and a reduction in the number of women diagnosed with pneumonia and chronic obstructive pulmonary disease (COPD) would make a difference.

Has health improved in the last few years?

Deaths from all causes

A total of 2693 deaths were registered in 2006-08 - an average of 898 deaths per year. Of these deaths 1315 were men (48.8% of total) and 1378 were women.

There were 13 infant deaths (under one year of age) in Babergh over the same period.

Figure 5 shows trends in premature mortality in 1993-2008. Deaths from all causes among men aged under 75 years decreased from 409.2 deaths per 100,000 residents to 284.8: a decrease of 30.4%.

For women this rate decreased from 237.4 deaths per 100,000 residents to 162.1: a decrease of 31.7%. Mortality rates for deaths from all causes among men and women aged under 75 years were consistently lower in Babergh than in England and Wales.

What do people die of?

In Babergh in 2006-08 three main causes of death: cardiovascular disease, cancer and lung disease, accounted for 75.2% (2019/2685) of all deaths among persons aged 28 days and over.

For men, the mortality rate for bronchitis, emphysema and other chronic obstructive pulmonary diseases (COPD) in Babergh was significantly lower than the rate in the East of England.

For women, the mortality rates for malignant cancers and COPD were significantly lower than the rates in the East of England.

**Figure 5**

Age-standardised mortality rates.
Three year moving means of rates.
Deaths from all causes.
Males and females aged under 75 years.

**Source:** Data: NHS Clinical and Health Outcomes Knowledge Base (2010) Mortality from all causes.
NHS Information Centre (http://www.nchod.nhs.uk accessed 14 April 2010); Graph: Department of Public Health, NHS Suffolk
What are the influences on health?

Health Poverty Index

The Health Poverty Index gives some insight into reasons why some people are healthier than others. Find out more about this by turning to the glossary.

Figure 6 compares Babergh with England in 2005. Indicator scores range from 0: least health poverty (centre of chart), to 1: most health poverty (outside edge of chart). A full guide to the chart is given in the glossary. The chart indicates that Babergh is a relatively healthy district. Scores for most indicators for Babergh have better ranks than the scores for England. Outliers, where Babergh performed relatively poorly, include local government resourcing, health care resourcing, access to social care, and health capital.

The indicator for health capital measures an individual’s potential for health across the life course. The components of this indicator include low birthweight, and modelled estimates of blood pressure, cholesterol and obesity. The relatively poor score for health capital in Babergh may reflect the fact that the population of the district includes relatively high percentages of middle-aged and elderly people.

Place Survey

Another way of understanding health in an area is the Place Survey. Find out more about this by turning to the glossary.

Figure 7 shows the results for Babergh from the Place Survey for 2008.

In Babergh, activities for teenagers are considered to be the area most in need of improvement, although they are not among the most important issues overall. Public transport and affordable decent housing are also considered to be areas in need of improvement.

Health services and the level of crime are considered to be the most important issues by survey respondents but are not thought to be in particular need of improvement.

What is the overall level of deprivation?

The Index of Multiple Deprivation 2007 is used as a measure of relative poverty and affluence across England (see glossary for further explanation).

Source: Place Survey (2008) Suffolk County Council
To describe the area one can look at geographic areas (loosely equivalent to electoral wards) called lower-layer Super Output Areas or LSOAs. None of the LSOAs in Babergh was categorised among the most deprived fifth in England. Only 9.4% of the population of Babergh lived in LSOAs in the second most deprived fifth in England. Almost 80% of the population of Babergh lived in areas classified as “less deprived” or “least deprived”.

What are future trends for common diseases?

One of the consequences of the projected growth in older people across Suffolk is an increase in the diseases of older age and people suffering from long term conditions.

Cardiovascular disease

Cardiovascular disease includes coronary heart disease, cerebrovascular disease (stroke-related illness) and other diseases of the circulatory system.

The estimated prevalence of cardiovascular disease is higher in Babergh than in
England as a whole. Between 2010 and 2020 the estimated prevalence of cardiovascular
disease among people aged 16 years and over in Babergh is projected to increase from
7.2% to 8.3%.

Coronary heart disease
The estimated prevalence of coronary heart disease is higher in Babergh than in
England as a whole. Between 2010 and 2020 the estimated prevalence of cardiovascular
disease among people aged 16 years and over in Babergh is projected to increase from
2.8% to 3.2%.

Hypertension (high blood pressure)
The estimated prevalence of hypertension is higher in Babergh than in England as a whole. Between 2010 and 2020 the estimated prevalence of hypertension among people aged 16 years and over in Babergh is projected to increase from 32.8% to 35.2%.

Diabetes
The estimated prevalence of diabetes is higher in Babergh than in England as a whole. Between 2010 and 2020 the estimated prevalence of diabetes among people aged 16 years and over in Babergh is projected to increase from 5.9% to 6.7%.

What sort of lifestyles do people have?
This section includes information on the demographic profile, participation in exercise, healthy eating, obesity, smoking and alcohol misuse, four healthy behaviours, and teenage conceptions.

Demographic profile – Social profile of Babergh
In comparison to Suffolk county, Babergh has a higher proportion of affluent professionals, affluent towns and villages and home-owning older couples. In other words, Babergh has a higher percentage of people with higher incomes who tend to have better health and lifestyle behaviours. Potential problems for this group may be that they have a relatively high level of both alcohol consumption and dining out.

Further detail is available in the full profile on the internet at: www.suffolk.nhs.uk.

Participation in exercise
In the academic year 2007-08 a total of 93.3% of children attending state schools in Babergh belonging to the Sport Partnership, reported taking part in a minimum of 2 hours of quality PE and sport within the curriculum each week. This percentage was significantly higher than the percentages for Suffolk county (89.7%), the
East of England (91.9%) and England as a whole (90.0%).

According to the East of England Lifestyle Survey, in 2008 and 2009 a total of 51.2% of people aged 16 years and over in Babergh reported taking the recommended level of physical activity each week. This figure was higher than, but not significantly different from NHS Suffolk (43.6%) and the East of England (41.8%).

In 2008 and 2009 a total of 7.1% of people aged 16 years and over in Babergh reported consuming five portions of fruit and vegetables on less than one day each week. This figure was lower than, but not significantly different from NHS Suffolk (12.5%) and the East of England (13.9%).

Healthy eating

In 2008 and 2009 a total of 41.4% of people aged 16 years and over in Babergh reported consuming the recommended five portions of fruit and vegetables on 5-7 days per week. This figure was higher than, but not significantly different from NHS Suffolk (43.6%) and the East of England (41.8%).

Obesity

• Childhood obesity
In the academic year 2008-09 the prevalence of obesity in children in Reception Year (age 4-5 years) was lower in Babergh (8.1%) than in Suffolk county (8.3%; not significantly different), the East of England (8.7%; not significantly different) and England as a whole (9.6%; not significantly different). In the academic year 2008-09 the prevalence of obesity in children in Year six (age 10-11 years) was lower in Babergh (13.0%) than in Suffolk county (15.2%; not significantly different), the East of England (16.6%; significantly different) and England as a whole (18.3%; significantly different).

• Adult obesity
In 2008-09 the East of England Lifestyle Survey found that 15.5% of the Babergh population (aged 16 years and older) were classified as obese or morbidly obese. This was not significantly different from the NHS Suffolk (15.7%) or the East of England (16.7%) average.

The East of England Lifestyle Survey was administered by telephone which meant that participants’ actual height and weight was not measured. This may explain why the obesity estimates are lower than other national estimates. In essence people tend to overestimate their height and underestimate their weight.

Smoking

• Prevalence of smoking
In 2008 and 2009 the prevalence of smoking among adults in Babergh was 21.6%. This figure was not significantly different from the prevalence of smoking in the area covered by NHS Suffolk (18.1%) or in the East of England (18.8%).

• Deaths from smoking
Smoking is a major preventable cause of death. In 2005-07 an estimated 383 deaths among residents of Babergh aged 35 years and over were attributed to smoking. However, in 2005-07 the rate of smoking-attributable mortality in Babergh (156.0 deaths per 100,000 residents aged 35 years and over), was
relatively low compared to Suffolk county (170.9) and the East of England (185.0).

Hazardous and harmful drinking
In 2008 and 2009 a total of 24.2% of the population of Babergh reported hazardous and harmful levels of alcohol consumption. This figure was not significantly different from the NHS Suffolk area (19.2%) and the East of England (20.5%).

Four healthy behaviours
In 2008 and 2009 a total of 6.8% of people aged 16 years and over in Babergh reported taking part in four healthy behaviours. These are defined as not smoking, eating five portions of fruit and vegetables 5-7 days per week, taking the recommended level of physical exercise and not drinking more than the recommended number of alcohol units per week.

This figure was not significantly different from the NHS Suffolk area (6.9%) and the East of England (6.7%).

Teenage conceptions
The teenage conception rate in Babergh is relatively low and decreasing.

In 2005-07 there were 124 conceptions among girls aged under 18 years in Babergh. A total of 54.0% of these conceptions led to abortion. Between 1998-2000 and 2005-07 the teenage conception rate in Babergh decreased by 22.6% from 30.0* conceptions to 23.2* among girls aged under 18 years (*per 1000 girls aged 15-17 years).

In 2004-06 there were 19 conceptions among girls aged under 16 years in Babergh. A total of 78.9% of these conceptions led to abortion.

Visit www.suffolk.nhs.uk for a more detailed profile that includes information on many of the social determinants of health, such as physical environment, economy, housing and education.

Optua – Health Inclusion Programme
Optua’s Health Inclusion Programme (HIP) was a pilot programme which ran from March 2007 to October 2009 and was funded by the West Suffolk Local Strategic Partnership.

The project was triggered by the Active People Survey conducted by Sport England which found that between 73% and 77% of disabled people living in the areas of Babergh, Forest Heath and St Edmundsbury were not actively taking part in regular sport or recreation.

HIP aimed to provide disabled people in west Suffolk with a personal tailored fitness programme in their local gym to improve their fitness and health. The initiative involved a 24-week programme tailored to suit people’s individual needs.

Gym sessions were also offered at only £1 and there were other incentives to encourage better use of leisure centres.

Some 109 people registered with the HIP. Not all of these finished the full 24-week programme but many people reported significant benefits. One participant’s blood pressure dropped and they saw an improvement in their pulse rate. HIP was particularly successful in Bury St Edmunds where five people attended over 30 sessions and several also took up swimming more regularly.

James, who attended the gym in Great Cornard, said: “I have enjoyed the sessions immensely. Since completing the programme I am much less reliant on my wheelchair. I also made new friends and found the staff incredibly helpful and caring throughout the experience.”
The Big Babergh Initiative (BBI) is one strand of the Active South Suffolk Partnership, led by Babergh District Council, which aims to promote more active healthy lifestyles in Babergh. The BBI is focused on encouraging children and young people aged between 5 and 19 to participate in active play and leisure.

The BBI provides free activity sessions during the school holiday periods for all, regardless of income or ability. As transport is a major problem in a rural district, the BBI team works with local communities and groups including parish councils to secure the use of local playing fields and community facilities. It means people do not have to travel and allowed the BBI team to target areas of rural isolation and deprivation.

Activities organised by BBI, including opportunities to just ‘turn up and play’, have increased in popularity with three times as many attendances in summer 2009 compared with the previous year. The fun days and new family camping events held in Sudbury and Holbrook proved to be very popular with families. Feedback from both parents and children and young people has been very positive. Activities offered have included a climbing wall, sailing, cycling, music workshops, arts and crafts, nutrition/food workshops, kite making, karate, den building, Kangoo Jumps™, dance, skate park, swimming and circus skills.

Testimonial:
“
I loved going to The BBI Project over the summer because there were loads of different activities and I made new friends. I really enjoyed the climbing wall and hanging out with my mates.
"
Babergh is committed to reducing fuel poverty within its community through referrals to an agency, Warm Front, for insulation and heating grants. In 2007 it was finding it increasingly hard to reach those most in need.

Babergh recognised that this would be best achieved by direct contact with people in their homes. One solution was found through approaching health and voluntary sector staff, who regularly visited the homes of the people who needed support.

Working with NHS Suffolk, other councils and voluntary organisations, Babergh was able to identify these staff. Babergh developed a training programme with partners to help the visitors identify fuel poverty in the homes of people they worked with and to give them expert referral advice.

Warm Front spend in Babergh increased by 40% from 2008 to 2009. It is acknowledged that rising fuel prices may have been a factor in increasing applications.

Tackling Fuel Poverty – Warmer Homes for Older People in West Suffolk

Sudbury Hosts Family Fun Day

A day out for all the family with an array of fun activities for children and families to enjoy together was held in January 2010.

Activities at Kingfisher Leisure Centre included free taster sessions such as Kangoo Jumps™, karate and health walks. Demonstrations and stalls included messy arts and crafts, homemade bread demonstrations, as well as health advice and activities.

Staff at Hadleigh Swimming Pool organised some taster swimming lessons, followed by dive scuba trial sessions and family “it’s a knockout”, which involved parents and children having fun together.

Following the success of the event, another is due to take place in September 2010.
West Suffolk MIND – ‘Think Smart Drink Smart’ Course

West Suffolk local strategic partnership (LSP) has funded a course called ‘Think Smart Drink Smart’ to help people beat alcohol dependency.

The course is run by West Suffolk MIND and helps people examine their own relationship with alcohol and decide what they want to do about it.

Bill* from Bury St Edmunds was one of the participants in the pilot group for the course and this is his story:

“My problem with alcohol started over 40 years ago when I was about 20 years old. I didn’t realise then that experimentation with alcohol could develop into something more sinister. I always had a rather rocky relationship with my father and we got into the routine of meeting down at the pub most evenings at about 6pm. It was the one place we talked and it was cosy and warm and we often ended up drinking far too much. When you do something like that with a parent it’s like getting their approval so you think it is OK.

I started a career in the Royal Navy where alcohol was easily available and we would think nothing of having four pints at lunchtime, more after work and then more when we got home.

I moved on to self-employment and the long hours encouraged me to turn to a glass of wine or treble gin even more frequently as a way to unwind. I developed cancer, which was attributed to my heavy drinking and smoking, and my business started failing. I was heavily depressed and on Prozac. After years on the drug I saw my GP and said I wanted to come off the Prozac. He said I had to get off the drink first but when I asked how to do it he had few practical ideas how to help.

My second wife saw an advert in a local paper for the ‘Think Smart Drink Smart’ course, showed it to me and asked what I thought. This was a real turning point. The course was quite exceptional. It was very professionally run but had warmth and compassion, and although everyone in the group was very different, we formed an incredibly strong bond.

What do you say to someone who gave you your life back? Thank you, West Suffolk MIND and the West Suffolk LSP for outstanding professionalism and care. Your way works.”

*Name changed to protect the individual’s identity
How long do people live and what is the potential for better health?

In 2006-08 it was estimated that men live to about 79 years old and women to 84 years, which is in line with the county as a whole and with England and Wales.

In 2003-07 the difference in life expectancy at birth for men living in the most deprived parts of Forest Heath compared to those living in the most affluent parts of the district was approximately four months. For women this gap in life expectancy was 1.9 years.

A PROFILE OF Forest Heath district

If 100 people lived in Forest Heath, then:

- 24 would be children (0 to 18 years) and 76 would be adults (19 years and above)
- Nobody would live in the most deprived areas where their health may be worse
- 10% of children aged 4 to 5 years and 17% of children aged 10 to 11 years would be overweight or obese
- 4 people aged 16 years and over would have coronary heart disease
- 3 people aged 16 years and over would have lung disease
- 46 people aged 16 years and over would take enough exercise
- 45 people aged 16 years and over would eat enough fruit and vegetables
- 21 people aged 16 years and over would smoke
- 24 people aged 16 years and over would drink too much alcohol
Reducing mortality from coronary heart disease, stroke, and other cancers in men in the most deprived fifth of the population would achieve the greatest gains. A reduction in the number of women dying from lung cancer in the most deprived fifth of the population would make a difference to female life expectancy.

**Has health improved in the last few years?**

**Deaths from all causes**

A total of 1400 deaths from all causes among residents of Forest Heath were registered in 2006-08: an average of 467 deaths per year. In Forest Heath in 2006-08 there were 706 deaths among men (50.4% of total) and 694 deaths among women. There were 11 infant deaths (under one year of age) in Forest Heath in 2006-08.

**Figure 9**

Years of life expectancy gained if the most deprived fifth of the population in Forest Heath had the same mortality rates as the least deprived fifth. Deaths from selected causes. Residents of Forest Heath district 2001-05.

Figure 10 shows trends in premature mortality in 1993-2008. Deaths from all causes among men aged under 75 years decreased from 432.9 deaths per 100,000 residents to 301.5: a decrease of 30.4%. For women this rate decreased from 270.8 deaths per 100,000 residents to 184.0: a decrease of 32.1%.

**What do people die of?**

In Forest Heath in 2006-08 three main causes of death: cardiovascular disease, cancer and lung disease, accounted for 77.7% (1083/1394) of all deaths among persons aged 28 days and over.

For men, mortality rates for malignant cancers, cardiovascular disease, bronchitis, emphysema and COPD were not significantly different from mortality rates in the East of England.

For women, the mortality rates for malignant cancers, cardiovascular disease and COPD were not significantly different from the rates in the East of England.

**What are the influences on health?**

**Health Poverty Index**

The Health Poverty Index gives some insight into reasons why some people are healthier than others. Find out more about this by turning to the glossary. Figure 11 compares Forest Heath with England in 2005. Indicator scores range from 0: least health poverty (centre of chart), to 1: most health poverty (outside edge of chart). A full guide to the chart is given in the glossary.

The chart for Forest Heath indicates that the district is a relatively healthy area. Scores for most indicators for Forest Heath have better ranks than the scores for England. Outliers, where Forest Heath performed relatively poorly, include social capital, wealth, human capital, preventative care resourcing, health care resourcing and access to social care.

Some of the outliers in this chart, such as preventative care resourcing and health care resourcing, may be the effect of not taking full account in the Health Poverty Index of services provided to the population of US service personnel in Forest Heath.

**Place Survey**

Another way of understanding health in an area is the Place Survey. Find out more about this by turning to the glossary. Figure 12 shows the results for Forest Heath from the Place Survey for 2008.

In Forest Heath, activities for teenagers and the level of traffic congestion are considered to be areas in need of most improvement, although they are not among the most important issues overall.

Public transport and affordable decent housing are also areas considered to be in need of improvement in Forest Heath.

The level of crime is considered to be the most important issue by survey respondents but is not thought to be in particular need of improvement.

**What is the overall level of deprivation?**

The Index of Multiple Deprivation 2007 is used as a measure of relative poverty and affluence across England (see glossary for further explanation).

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Source: Place Survey (2008) Suffolk County Council
Figure 13 shows this information for Forest Heath in comparison to Suffolk as a whole, the East of England and the whole country.

To describe the area one can also look at geographic areas (loosely equivalent to electoral wards) called lower-layer Super Output Areas or LSOAs. None of the LSOAs in Forest Heath was categorised among the most deprived fifth in England. Only 5.2% of the population of Forest Heath lived in LSOAs in the second most deprived fifth in England. Over 70% of the population of Forest Heath lived in areas classified as “less deprived” or “least deprived”.

**What are future trends for common diseases?**

One of the consequences of the projected growth in older people across Suffolk is an increase in the diseases of older age and people suffering from long term conditions.

**Cardiovascular disease**

Cardiovascular disease includes coronary heart disease, cerebrovascular disease (stroke-related illness) and other diseases of the circulatory system.

The estimated prevalence of cardiovascular disease is lower in Forest Heath than in England as a whole. Between 2010 and 2020
the estimated prevalence of cardiovascular disease among people aged 16 years and over in Forest Heath is projected to increase from 5.3% to 6.0%.

**Coronary heart disease**
The estimated prevalence of coronary heart disease is lower in Forest Heath than in England as a whole. Between 2010 and 2020 the estimated prevalence of coronary heart disease among people aged 16 years and over in Forest Heath is projected to increase from 4.4% to 4.9%.

**Hypertension (high blood pressure)**
The estimated prevalence of hypertension is lower in Forest Heath than in England as a whole. Between 2010 and 2020 the estimated prevalence of hypertension among people aged 16 years and over in Forest Heath is projected to increase from 26.4% to 28.2%.

**Chronically obstructive pulmonary (lung) disease**
The estimated prevalence of chronic obstructive pulmonary disease (COPD) is lower in Forest Heath than in England as a whole. Between 2010 and 2020 the estimated prevalence of COPD among people aged 16 years and over in Forest Heath is projected to increase from 2.1% to 2.4%.

**Diabetes**
The estimated prevalence of diabetes is lower in Forest Heath than in England as a whole. Between 2010 and 2025 the estimated prevalence of diabetes among people of all ages in Forest Heath is projected to increase from 4.1% to 5.3%

**Stroke**
The estimated prevalence of stroke is lower in Forest Heath than in England as a whole. Between 2010 and 2020 the estimated prevalence of stroke among people aged 16 years and over in Forest Heath is projected to increase from 2.1% to 2.4%.

This section includes information on the demographic profile, participation in exercise, healthy eating, obesity, smoking and alcohol misuse, four healthy behaviours, and teenage conceptions.

**Demographic profile – Social profile of Forest Heath**
Data shows that the population of Forest Heath has a combination of both affluent and mixed towns and villages, and that health and lifestyle behaviours of the population range from average to good.

In comparison to Suffolk county, Forest Heath has higher levels of younger, affluent, healthy professionals, affluent families and also, conversely, low income families who are likely to smoke. Further detail is available in the full profile on the internet at: www.suffolk.nhs.uk.

**Participation in exercise**
In the academic year 2007-08 a total of 92% of children attending state schools in Forest Heath belonging to the Sport Partnership, reported taking part in a minimum of two hours of quality PE and sport within the curriculum each week. This percentage was higher than the percentages for Suffolk county (89.7%; significantly different), the East of England (91.9%; not significantly different) and England as a whole.
According to the East of England Lifestyle Survey, in 2008 and 2009 a total of 45.8% of people aged 16 years and over in Forest Heath reported taking the recommended level of physical activity each week. This figure was slightly lower than, but not significantly different from the percentage in NHS Suffolk (45.9%) and higher than, but not significantly different from the percentage in the East of England (43.3%).

**Healthy eating**

In 2008 and 2009 a total of 44.7% of people aged 16 years and over in Forest Heath reported consuming the recommended five portions of fruit and vegetables on 5-7 days per week. This figure was higher than, but not significantly different from the percentages in NHS Suffolk (43.6%) and the East of England (41.8%).

In 2008 and 2009 a total of 11.1% of people aged 16 years and over in Forest Heath reported consuming five portions of fruit and vegetables on less than one day each week. This figure was lower than but not significantly different from the percentages in NHS Suffolk (12.5%) and the East of England (13.9%).

**Obesity**

- **Childhood obesity**

  In the academic year 2008-09 the prevalence of obesity in children in Reception Year (age 4-5 years) was higher in Forest Heath (10.2%) than in Suffolk county (8.3%; not significantly different), the East of England (8.7%; not significantly different) and England as a whole (9.6%; not significantly different).

  In the academic year 2008-09 the prevalence of obesity in children in Year six (age 10-11 years) was higher in Forest Heath (16.7%) than in Suffolk county (15.2%; not significantly different) and the East of England (16.6%; not significantly different). Prevalence of obesity in Year six children was lower in Forest Heath than in England as a whole (18.3%; not significantly different).

- **Adult obesity**

  In 2008/09 the East of England Lifestyle Survey found that 19.5% of the Forest Heath population (aged 16 years and older) were classified as obese or morbidly obese. This was not significantly different from the NHS Suffolk (15.7%) or the East of England (16.7%) average. The East of England Lifestyle Survey was administered by telephone which meant that participants’ actual height and weight was not measured. This may explain why the obesity estimates are lower than other national estimates. In essence people tend to overestimate their height and underestimate their weight.

**Smoking**

- **Prevalence of smoking**

  In 2008 and 2009 the prevalence of smoking among adults in Forest Heath was 20.6%. This figure was higher than but not significantly different from the prevalence of smoking in the area covered by NHS Suffolk (18.1%) or in the East of England (18.8%).

- **Deaths from smoking**

  Smoking is a major preventable cause of death.
In 2005-07 an estimated 244 deaths among residents of Forest Heath aged 35 years and over were attributed to smoking. In 2005-07 the rate of smoking-attributable mortality in Forest Heath was higher than, but not significantly different from the rates in Suffolk county and the East of England.

**Four healthy behaviours**

In 2008 and 2009 a total of 6.4% of people aged 16 years and over in Forest Heath reported taking part in four healthy behaviours. These are defined as not smoking, eating five portions of fruit and vegetables 5-7 days per week, taking the recommended level of physical exercise and not drinking more than the recommended number of alcohol units per week. This figure was lower than, but not significantly different from the percentages in NHS Suffolk (6.9%) and the East of England (6.7%).

In 2005-07 there were 77 conceptions among girls aged under 18 years in Forest Heath. A total of 49.0% of these conceptions led to abortion. Teenage conception rates in Forest Heath are relatively low. Between 1998-2000 and 2005-07 the teenage conception rate in Forest Heath decreased by 4.5% from 25.1* conceptions to 24.0* among girls aged under 18 years (*per 1000 girls aged 15-17 years).

In 2004-06 there were 16 conceptions among girls aged under 16 years in Forest Heath. Fewer than 10 of these conceptions led to abortion.

Visit www.suffolk.nhs.uk for a more detailed profile that includes information on many of the social determinants of health, such as environment, economy, housing and education.

**Hazardous and harmful drinking**

In 2008 and 2009 a total of 24.2% of the population of Forest Heath reported hazardous and harmful levels of alcohol consumption. This figure was higher than but not significantly different from the NHS Suffolk area (19.2%) and the East of England (20.5%).

**Teenage conceptions**

The Brandon group consists of a mixture of health professionals (eg. dieticians, health visitors), other professionals from Forest Heath District Council, Children’s Centre, leisure centre and local councillors.

The group has developed and drafted a local Healthy Lifestyle guide for Brandon, which includes advice and guidance, local relevant services, groups and activities, and a map of the town with activities signposted.

A breastfeeding questionnaire has been drafted to find out awareness of local services, knowledge and attitudes.

Plans for the future include a public consultation on the Healthy Lifestyle guide prior to publication, and asking people to complete the breastfeeding questionnaire and analysing the results.

**Case study 1**

‘Reach Out’ in Brandon

The Brandon group consists of a mixture of health professionals (eg. dieticians, health visitors), other professionals from Forest Heath District Council, Children’s Centre, leisure centre and local councillors.
Suffolk Stop Smoking Service was keen to expand the Health Enhancement Rewards Scheme (HERS), working with pregnant women who smoke, across the whole of West Suffolk.

Forest Heath District Council (FHDC), with Suffolk County Council, established that Brandon would be the area most in need of the service. A specialist clinic was established giving one to one support from Brandon Children’s Centre for pregnant women or women with children under five years and their partners. It is too early to evaluate this at the moment, with referrals being low.

FHDC also has an advisor available to its staff. A number of members of staff have successfully used the service in the past, and there are three members of staff using the service so far in 2010. A specialist stop smoking service is offered at Newmarket Community Hospital as well as excellent work done by GPs and pharmacies in the area, demonstrating that FHDC is committed to reducing smoking prevalence and improving the health of its population.
If 100 people lived in Ipswich, then:

- 23 would be children (0 to 18 years) and 77 would be adults (19 years and above)
- 24 would live in the most deprived areas where their health may be worse
- 8% of children aged 4 to 5 years and 16% of children aged 10 to 11 years would be overweight or obese
- 6 people aged 16 years and over would have coronary heart disease
- 4 people aged 16 years and over would have lung disease
- 42 people aged 16 years and over would take enough exercise
- 40 people aged 16 years and over would eat enough fruit and vegetables
- 20 people aged 16 years and over would smoke
- 18 people aged 16 years and over would drink too much alcohol

How long do people live and what is the potential for better health?

In 2006-08 it was estimated that men live to about 78 years old and women to 83 years, which is in line with the county as a whole, and with England and Wales.

In 2003-07 the difference in life expectancy at birth for men living in the most deprived parts of Ipswich compared to those living in the most affluent parts of the district was 3.4 years. For women this gap in life expectancy was 7.2 years.
Figure 14
Years of life expectancy gained if the most deprived fifth of the population in Ipswich had the same mortality rates as the least deprived fifth. Deaths from selected causes. Residents of Ipswich borough 2001-05

Reducing mortality from coronary heart disease, suicide, lung cancer, pneumonia and road traffic and other accidents in men, in the most deprived fifth of the population, would achieve the greatest gains. For the same group, a reduction in the number of women dying from coronary heart disease, other cancers, pneumonia and chronic obstructive pulmonary disease (COPD) would make a difference.

Has health improved in the last few years?

Deaths from all causes

A total of 3387 deaths from all causes among residents of Ipswich were registered in 2006-08: an average of 1129 deaths per year. In Ipswich in 2006-08 there were 1643 deaths among men (48.5% of total) and 1744 deaths among women. There were 29 infant deaths (under one year of age) in Ipswich in 2006-08. Figure 15 shows trends in premature mortality in 1993-2008. Deaths from all causes among men aged under 75 years decreased from 503.2 deaths per 100,000 residents to 366.9: a decrease of 30.4%. For women this rate decreased from 294.7 deaths per 100,000 residents to 208.5: a decrease of 29.3%. In recent years mortality rates for deaths from all causes among men and women aged under 75 years in Ipswich have increased slightly but were lower than in England and Wales.

What do people die of?

In Ipswich in 2006-08 three main causes of death: cardiovascular disease, cancer and lung disease, accounted for 76.2% (2568/3368) of all deaths among persons aged 28 days and over.

For men, the mortality rates for malignant cancer and cardiovascular disease in Ipswich were significantly higher than the East of England. Mortality rates for bronchitis, emphysema and COPD was not significantly different from the East of England.

For women, the mortality rates for malignant cancer, circulatory disease and COPD were not significantly different from the rates in the East of England.

**Figure 15**


**Source:** Data: NHS Clinical and Health Outcomes Knowledge Base (2010) Mortality from all causes. NHS Information Centre (http://www.nchod.nhs.uk; accessed 14 April 2010); Graph: Department of Public Health, NHS Suffolk
What are the influences on health?

Health Poverty Index

The Health Poverty Index gives some insight into reasons why some people are healthier than others. Find out more about this by turning to the glossary.

Figure 16 compares Ipswich with England in 2005. Indicator scores range from 0: least health poverty (centre of chart), to 1: most health poverty (outside edge of chart). A full guide to the chart is given in the glossary.

The chart for Ipswich indicates areas of relative health poverty in the district. Outliers, where Ipswich performed relatively poorly, include change in job supply, income, wealth, human capital, lifestyle, home environments, work and local environments, access to social care and psychological morbidity. Ipswich was also ranked worse than England for Gross Value Added per capita, preventative care resourcing, physical morbidity and premature mortality.

Health poverty in Ipswich relates mainly to certain economic and social indicators, particularly in the domains of household conditions, and behaviours and environments. The chart indicates that Ipswich has relatively good health care and also good educational quality, social capital and recreation facilities.

Place Survey

Another way of understanding health in an area is the Place Survey. Find out more about this by turning to the glossary. Figure 17 shows the results for Ipswich from the Place Survey for 2008.

In Ipswich, activities for teenagers, congestion and road and pavement repairs are considered to be the areas most in need of improvement, although they are not among the most important issues overall. The level of crime and clean streets are considered to be the most important issues by survey respondents, and are also deemed to be areas where improvement is needed.

Figure 17 shows the results for Ipswich from the Place Survey for 2008. In Ipswich, activities for teenagers, congestion and road and pavement repairs are considered to be the areas most in need of improvement, although they are not among the most important issues overall. The level of crime and clean streets are considered to be the most important issues by survey respondents, and are also deemed to be areas where improvement is needed.

What is the overall level of deprivation?

The Index of Multiple Deprivation 2007 is used as a measure of relative poverty and affluence across England (see glossary for further explanation).

Figure 18 shows this information for Ipswich in comparison to Suffolk as a whole, the East of England and the whole country.

To describe the area we can also look at geographic areas (loosely equivalent to electoral wards) called lower-layer Super Output Areas or LSOAs. Over 24% of the population of Ipswich lived in LSOAs in the most deprived fifth in England.

Source: Place Survey (2008) Suffolk County Council
Around 26% of the population of Ipswich lived in LSOAs in the second most deprived fifth in England. Around 28% of the population of Ipswich lived in areas classified as “less deprived” or “least deprived”.

What are future trends for common diseases?

One of the consequences of the projected growth in older people across Suffolk is an increase in the diseases of older age and people suffering from long term conditions. Cardiovascular disease includes coronary heart disease, cerebrovascular disease (stroke-related illness) and other diseases of the circulatory system.

In 2010, the estimated prevalence of cardiovascular disease is higher in Ipswich than in England as a whole, and will remain the same until 2015 but the trend will reverse in 2020. Between 2010 and 2020 the estimated prevalence of cardiovascular disease among people aged 16 years and over in Ipswich is projected to increase from 6.8% to 7.2%.

Coronary heart disease

The estimated prevalence of coronary heart disease is predicted to be higher in Ipswich than in England as a whole until 2015, but the figures for Ipswich and

Source: Eastern Region Public Health Observatory (ERPHO) (2009), Health Profile 2009
England as a whole will be the same in 2020. Between 2010 and 2020 the estimated prevalence of coronary heart disease among people aged 16 years and over in Ipswich is projected to increase from 5.9% to 6.2%.

**Stroke**

In 2020, the estimated prevalence of stroke will be higher in England as a whole than in Ipswich, but the figures for Ipswich and England as a whole will remain the same in 2010 and 2015. Between 2010 and 2020 the estimated prevalence of stroke among people aged 16 years and over in Ipswich is projected to increase from 30.0% to 30.9%.

**Hypertension (high blood pressure)**

The estimated prevalence of hypertension is lower in Ipswich than in England as a whole. Between 2010 and 2020 the estimated prevalence of hypertension among people aged 16 years and over in Ipswich is projected to increase from 3.5% to 3.6%.

**Diabetes**

The estimated prevalence of diabetes is lower in Ipswich than in England as a whole. Between 2010 and 2025 the estimated prevalence of diabetes among people of all ages in Ipswich is projected to increase from 2.5% to 2.7%.

**Chronic obstructive pulmonary (lung) disease**

The estimated prevalence of chronic obstructive pulmonary disease (COPD) is lower in Ipswich than in England as a whole. Between 2010 and 2020 the estimated prevalence of COPD among people aged 16 years and over in Ipswich is projected to increase from 3.5% to 3.6%.

**Demographic profile – Social profile of Ipswich**

In comparison to Suffolk county, Ipswich has higher levels of poorer single parent families who are more likely to have lifestyle related illnesses, as well as older people with chronic health problems, smokers and problems of obesity. There are lower levels of affluent professionals.

Further detail is available in the full profile on the internet at: [www.suffolk.nhs.uk](http://www.suffolk.nhs.uk).

**What sort of lifestyles do people have?**

This section includes information on the demographic profile, participation in exercise, healthy eating, obesity, smoking and alcohol misuse, four healthy behaviours, and teenage conceptions.

**Participation in exercise**

In the academic year 2007-08 a total of 89.1% of children attending state schools in Ipswich belonging to the Sport Partnership, reported taking part in a minimum of two hours of quality PE and sport within the curriculum each week. This percentage was not significantly different than the percentage for Suffolk (89.7%), but was significantly lower than the percentages for the East of England (91.9%) and England as a whole (90.0%).

According to the East of England Lifestyle Survey, in 2008 and 2009 a total of 42.2% of people aged 16 years and over in Ipswich reported taking the recommended level of physical activity each week. This figure was lower than, but not significantly different from NHS Suffolk (45.9%) and the East of England (43.3%).
**Healthy eating**

In 2008 and 2009 a total of 40.2% of people aged 16 years and over in Ipswich reported consuming the recommended five portions of fruit and vegetables on 5-7 days per week. This figure was lower than, but not significantly different from NHS Suffolk (43.6%) and the East of England (41.8%).

In 2008 and 2009 a total of 15.2% of people aged 16 years and over in Ipswich reported consuming five portions of fruit and vegetables on less than one day each week. This figure was higher than, but not significantly different from NHS Suffolk (12.5%) and East of England (13.9%).

**Obesity**

- **Childhood obesity**
  In the academic year 2008-09 the prevalence of obesity in children in Reception Year (ages 4-5 years) was lower in Ipswich (8.2%) than in Suffolk (8.3%; not significantly different), the East of England (8.7%; not significantly different) and England as a whole (9.6%; not significantly different).

  In the academic year 2008-09 the prevalence of obesity in children in Year six (ages 10-11 years) was lower in Ipswich (15.7%) than in the East of England (16.6%; not significantly different) and England as a whole (18.3%; significantly different), but higher than in Suffolk (15.2%; not significantly different).

- **Adult obesity**
  In the academic year 2008-09 totals of 11.4% of Reception Year children and 12.3% of Year six children in Ipswich were recorded as overweight but not obese.

  In the academic year 2008-09 the East of England Lifestyle Survey found that 15.9% of the Ipswich population (aged 16 years and older) were classified as obese or morbidly obese. This was not significantly different from the NHS Suffolk (15.7%) or the East of England (16.7%) average.

  The East of England Lifestyle Survey was administered by telephone which meant that participants’ actual height and weight was not measured. This may explain why the obesity estimates are lower than other national estimates. In essence, people tend to overestimate their height and underestimate their weight.

**Smoking**

- **Prevalence of smoking**
  In 2008 and 2009 the prevalence of smoking among adults in Ipswich was 20.4%. This figure was not significantly different from the prevalence of smoking in adults in Ipswich was 20.4%. This figure was not significantly different from the prevalence of smoking in adults in Ipswich was 20.4%. This figure was not significantly different from the prevalence of smoking in adults in Ipswich was 20.4%. This figure was not significantly different from the prevalence of smoking in adults in Ipswich was 20.4%.

  In 2005-07 an estimated 530 deaths among residents of Ipswich aged 35 years and over were attributed to smoking. In 2005-07 the rate of smoking-attributable mortality among individuals aged 35 years and over in Ipswich was higher than but not significantly different from the rates in Suffolk county and the East of England.

**Hazardous and harmful drinking**

- **Deaths from smoking**
  Smoking is a major preventable cause of death.

  In 2008 and 2009 a total of 18.1% of the population of Ipswich reported hazardous and harmful levels of alcohol consumption. This figure was lower than, but not significantly different from the NHS Suffolk area (19.2%) and the East of England (20.5%).
Four healthy behaviours
In 2008 and 2009 a total of 6.2% of people aged 16 years and over in Ipswich reported taking part in four healthy behaviours. These are defined as not smoking, eating five portions of fruit and vegetables 5-7 days per week, taking the recommended level of physical exercise and not drinking more than the recommended number of alcohol units per week. This figure was lower than but not significantly different from NHS Suffolk (6.9%) and the East of England (6.7%).

Teenage conceptions
In 2005-07 there were 338 conceptions among girls aged under 18 years in Ipswich. 43.0% of these conceptions led to abortion. The teenage conception rate in Ipswich is high. In 2005-07 the teenage conception rate in Ipswich was significantly higher than the rate in England and Wales as a whole. However, between 1998-2000 and 2005-07 the teenage conception rate in Ipswich decreased by 12.1% from 53.7* conceptions to 47.2*, among girls aged under 18 years (*per 1000 girls aged 15-17 years).

In 2004-06 there were 68 conceptions among girls aged under 16 years in Ipswich. A total of 57.4% of these conceptions led to abortion.

Visit www.suffolk.nhs.uk for a more detailed profile that includes information on many of the social determinants of health, such as physical environment, economy, housing and education.

The Town and Bridge Project
The Town and Bridge (T&B) Project was the first multi-agency project adopted by the One-Ipswich local strategic partnership (LSP).

A ten year project which started in January 2005, it is aimed at improving the health of people aged 45-74 living in the central part of Ipswich – an area that has historically had the worst health record in Suffolk.

The area covered by the T&B project stretches from the Yarmouth Road and Chevallier Street in the west, to Grimwade Street in the east; and from Bath Street in the south, across Stoke Hill to the Norwich Road and Fonnereau Road in the north.

While progress has been slower than originally anticipated due to lack of funding, notable successes include:

• The investment of over £100,000 in improving street lighting
• The investment of over £140,000 in addressing fuel poverty
• Winning a big lottery People’s Millions award of over £80,000 in 2007, which resulted in the creation of a community garden
• Being awarded over £90,000 in 2008, through the Age Concern ‘fit as a fiddle’ Programme, to support and empower disadvantaged people to make positive changes to their lifestyle and to improve their health and wellbeing.
The Town and Bridge Project has been spreading the healthy living message to all ages with their recent “Love Your Heart” event at the Westgate Social Club.

Over 80 attendees benefited from scrumptious, free food and refreshments, fun activities, such as T’ai Chi, quizzes, seed potting, face painting, dance and massage taster session, cookery demonstrations with many freebies and recipes to take away. The event was deemed a success and plans are being drawn up for another event in the Stoke area of Ipswich later in 2010.

**Case study 3**

“Love Your Heart” in the Town and Bridge area

Suffolk Young People’s Health Project – 4YP

4YP works with partners to provide services that address health inequalities amongst young people aged 12-25 and to improve their social, physical and emotional health and wellbeing.

Suffolk Young People’s Health Project - 4YP provides an environment that is warm, open, fun, friendly, safe and confidential for young people to be able to engage in a variety of activities, enhancing their holistic health and wellbeing.

The services and experiences provided allow for, and encourage, the growth in young people’s confidence, self-esteem, communication skills, respect and tolerance for others and their communities. Specialist services, support and activities include counselling, sexual health, Chlamydia screening, substance misuse, smoking cessation, information, support and guidance, cooking, nutritional and budgeting skills, life and social skills, and outdoor activities.
Commissioned by One Ipswich local strategic partnership, the overall aim of the Triangle Area Profile was to gain a realistic, evidence-based, understanding of the issues faced by residents living in and around the Triangle.

A lot of people are not familiar with the Triangle estate, and if they do know it, may refer to it as the Dickens Road estate. The origin of why it is called Triangle is geographical and refers to Hadleigh Road, London Road and Chantry Park as boundaries.

In keeping with One Ipswich’s strategy, this neighbourhood approach has enabled partners to more effectively target resources to address the issues identified. One Ipswich partners have been working hard together in 2009 to encourage healthy lifestyles on the Triangle. For example, a programme of physical activities including climbing and street dance has been organised by Suffolk County Council’s Youth Services with funding from Sport Unlimited, to help a group of disenfranchised young people lead healthier lifestyles, gain confidence and learn teamwork skills.

With funding from One Ipswich, a dedicated part time community development officer and support from the area’s police officer, the well-attended “Come Dine with Us” event generated interest amongst residents for family friendly cookery, gardening and exercise activities.

Since then, an exciting resident led initiative called “Trim up the Triangle” has been launched. The idea was born out of resident participation in an action learning trip to Manchester, organised by NHS Suffolk as part of the national Department of Health ‘Tackling Obesity through Community Engagement’ pilot.

**Case study 4**

**Partnership working on the Triangle estate in Ipswich bears fruit.**

**Case study 5**

**ISCRE has launched it’s first Leadership Academy**

The Suffolk charity charged with promoting equality and fighting discrimination in the county has launched a scheme aimed at improving the educational prospects of local African Caribbean pupils.

The Ipswich & Suffolk Council for Racial Equality (ISCRE) has launched its first Leadership Academy which ran for six days in August 2010 at both Suffolk New College and the Murrayside Community Centre in Ipswich. The Academy offers up to 20 places for African Caribbean children aged eight and over in school years four and five.

The programme for the Academy includes sessions on team-building, leadership, art, foreign languages and the importance of the pupils’ African heritage. It is expected those attending will have a greater level of confidence in their own academic abilities when they return to their schools in September. ISCRE and its partners hope to offer some ongoing mentoring to Academy pupils on a longer term basis as well.
Anglia Care Trust – Family Intervention Programme

The Family Intervention Programme (FIP) is currently funded by Ipswich Borough Council, Suffolk County Council, together with West Suffolk and Waveney community safety partnerships.

**Girl C**

At 15 years old, C was smoking 10 cigarettes a day and binge drinking at weekends. When she was 14 she had attended accident and emergency at Ipswich Hospital due to alcohol, and stayed overnight.

When she became pregnant her FIP Worker talked to her about health in pregnancy. C did not know that her alcohol and cigarette intake would affect the baby. She gave up smoking and drinking immediately, and with the support of her FIP worker, began attending mother and baby classes.

C has attended classes throughout her pregnancy and has continued to eat well, exercise and not drink alcohol. Her FIP worker encouraged and supported her to attend the initial midwife appointment, and she now attends the appointments alone.

**Family R**

Family R was referred to FIP in July 2008. There are eight family members living at the house. Dad works but was coming home and drinking eight cans of lager a night. Mum was not cooking or managing with the housework. The FIP assessment revealed that none of the family members was registered with a dentist. The FIP worker ensured that this was done immediately. It was also evident that vaccinations for the children were not up-to-date and this has since been addressed.

Since FIP has been involved, dad has reduced his alcohol intake to two cans a night and has attended an appointment with Norcas.

Another family member L, a 15-year-old, stated that she was sexually active and was not practicing safe sex. She has since agreed to have a sexual health check and contraception advice.
How long do people live and what is the potential for better health?

In 2006-08 it was estimated that men live to about 80 years old and women to 84 years, which is slightly higher than the county as a whole and for England and Wales.

In 2003-07 the difference in life expectancy at birth for men living in the most deprived parts of Mid Suffolk compared to those living in the most affluent parts of the district was 3.2 years. For women this gap in life expectancy was 3.4 years.

If 100 people lived in Mid Suffolk, then:

- 22 would be children (0 to 18 years) and 78 would be adults (19 years and above)
- Nobody would live in the most deprived areas where their health may be worse
- 8% of children aged 4 to 5 years and 12% of children aged 10 to 11 years would be overweight or obese
- 6 people aged 16 years and over would have coronary heart disease
- 3 people aged 16 years and over would have lung disease
- 50 people aged 16 years and over would take enough exercise
- 45 people aged 16 years and over would eat enough fruit and vegetables
- 19 people aged 16 years and over would smoke
- 16 people aged 16 years and over would drink too much alcohol
Reducing mortality from coronary heart disease and suicide in men in the most deprived fifth of the population would achieve the greatest gains. In the same group, reducing mortality from stroke and other cardiovascular disease in women would make a difference.

Has health improved in the last few years?

Deaths from all causes

A total of 2579 deaths from all causes among residents of Mid Suffolk were registered in 2006-08: an average of 860 deaths per year. In Mid Suffolk in 2006-08 there were 1267 deaths among men (49.1% of total) and 1312 deaths among women. There were 9 infant deaths (under one year of age) in Mid Suffolk in 2006-08.
Figure 20 shows trends in premature mortality in 1993-2008. Deaths from all causes among men aged under 75 years decreased from 396.3 deaths per 100,000 residents to 255.2: a decrease of 35.6%. For women this rate decreased from 263.8 deaths per 100,000 residents to 181.0: a decrease of 31.4%.

Mortality rates for deaths from all causes among men and women aged under 75 years were consistently lower in Mid Suffolk than in England and Wales.

What do people die of?
In Mid Suffolk in 2006-08 three main causes of death: cardiovascular disease, cancer and lung disease, accounted for 77.2% (1983/2570) of all deaths among people aged 28 days and over.

For both sexes, the mortality rates for malignant cancers and cardiovascular diseases in Mid Suffolk was not significantly different from the rate in the East of England. Mortality rates for bronchitis, emphysema and COPD were significantly lower than the East of England.

For women, the mortality rate for COPD was significantly lower than the rates in the East of England.

What are the influences on health?

Health Poverty Index

The Health Poverty Index gives some insight into reasons why some people are healthier than others. Find out more about this by turning to the glossary. Figure 21 compares Mid Suffolk with England in 2005. Indicator scores range from 0: least health poverty (centre of chart), to 1: most health poverty (outside edge of chart). A full guide to the chart is given in the glossary.

The chart in figure 21 indicates that Mid Suffolk is a relatively healthy area. Scores for most indicators had better ranks than the scores for England.

performed relatively poorly for recreational facilities, healthcare resourcing and access to social care. This is not necessarily a negative finding. For example, health care resourcing, which is measured as expenditure on hospital care, would be less in a district which has relatively low demand for hospital services.

Figure 21
Mid Suffolk: Ranked data, 2005, All ethnic groups
England: Ranked data, 2005, All ethnic groups
Place Survey

Another way of understanding health in an area is the Place Survey. Find out more about this by turning to the glossary. Figure 22 shows the results for Mid Suffolk from the Place Survey for 2008.

In Mid Suffolk, activities for teenagers are considered to be the area most in need of improvement, although they are not among the most important issues overall. Public transport and affordable decent housing are also considered to be areas in need of improvement.

Health services and the level of crime are considered to be the most important issues by survey respondents but are not thought to be in particular need of improvement.

What is the overall level of deprivation?

The Index of Multiple Deprivation 2007 is used as a measure of relative poverty and affluence across England (see glossary for further explanation).

Figure 23 shows this information for Mid Suffolk in comparison to Suffolk as a whole, the East of England and the whole country.

To describe the area one can also look at geographic areas (loosely equivalent to electoral wards) called lower-layer Super Output Areas or LSOAs. None of the LSOAs in Mid Suffolk was categorised among the most deprived fifth in England. Only 1.8% of the population of Mid Suffolk lived in LSOAs.

Babergh  
Forest Heath  
Ipswich  
Mid Suffolk  
St Edmundsbury  
Suffolk Coastal  
Waveney

in the second most deprived fifth in England. Over 95% of the population of Mid Suffolk lived in areas classified as “less deprived” or “least deprived”.

**What are future trends for common diseases?**

One of the consequences of the projected growth in older people across Suffolk is an increase in the diseases of older age and people suffering from long term conditions.

**Coronary heart disease**

The estimated prevalence of coronary heart disease is predicted to be higher in Mid Suffolk than in England as a whole by 2015. Between 2010 and 2020 the estimated prevalence of coronary heart disease among people aged 16 years and over in Mid Suffolk is projected to increase from 5.6% to 6.5%.

**Cardiovascular disease**

Cardiovascular disease includes coronary heart disease, cerebrovascular disease (stroke-related illness) and other diseases of the circulatory system.

The estimated prevalence of cardiovascular disease is higher in Mid Suffolk than in England as a whole. Between 2010 and 2020 the estimated prevalence of cardiovascular disease among people aged 16 years and over in Mid Suffolk is projected to increase from 6.8% to 7.9%.
A profile of Mid Suffolk district

Stroke
The estimated prevalence of stroke is higher in Mid Suffolk than in England as a whole. Between 2010 and 2020 the estimated prevalence of stroke among people aged 16 years and over in Mid Suffolk is projected to increase from 2.6% to 3.1%.

Hypertension (high blood pressure)
The estimated prevalence of hypertension is higher in Mid Suffolk than in England as a whole. Between 2010 and 2020 the estimated prevalence of hypertension among people aged 16 years and over in Mid Suffolk is projected to increase from 31.7% to 34.4%.

Diabetes
The estimated prevalence of diabetes is lower in Mid Suffolk than in England as a whole. Between 2010 and 2025 the estimated prevalence of diabetes among people of all ages in Mid Suffolk is projected to increase from 4.8% to 6.4%.

Chronic obstructive pulmonary (lung) disease
The estimated prevalence of chronic obstructive pulmonary disease (COPD) is lower in Mid Suffolk than in England as a whole. Between 2010 and 2020 the estimated prevalence of COPD among people aged 16 years and over in Mid Suffolk is projected to increase from 2.7% to 3.0%.

What sort of lifestyles do people have?
This section includes information on the demographic profile, participation in exercise, healthy eating, obesity, smoking and alcohol misuse, four healthy behaviours, and teenage conceptions.

Demographic profile – Social profile of Mid Suffolk
Data shows the population of Mid Suffolk as mainly a mixture of affluent towns and villages and affluent professionals. In other words, Mid Suffolk has a higher percentage of people with a higher income who tend to have better health and lifestyle behaviours.

Conversely, in comparison to Suffolk county, Mid Suffolk has a higher percentage of less affluent neighbourhoods that tend to include people who exhibit poor diet choices and live sedentary lifestyles.

Further detail is available in the full profile on the internet at: www.suffolk.nhs.uk.

Participation in exercise
In the academic year 2007-08 a total of 87.3% of children attending state schools in Mid Suffolk belonging to the Sport Partnership, reported taking part in a minimum of two hours of quality PE and sport within the curriculum each week. This percentage was significantly lower than the percentages for Suffolk county (89.7%), the East of England (91.9%) and England as a whole (90.0%).

According to the East of England Lifestyle Survey, in 2008 and 2009 a total of 50.0% of people aged 16 years and over in Mid Suffolk reported taking the recommended level of physical activity each week. This figure was higher than, but not significantly different from NHS Suffolk (45.9%) and the East of England (43.3%).

Healthy eating
In 2008 and 2009 a total of 44.9% of people aged 16 years and over in Mid Suffolk reported consuming...
the recommended five portions of fruit and vegetables on 5-7 days per week. This figure was higher than, but not significantly different from NHS Suffolk (43.6%) and the East of England (41.8%).

In 2008 and 2009 a total of 7.1% of people aged 16 years and over in Mid Suffolk reported consuming five portions of fruit and vegetables on less than one day each week. This figure was significantly lower than NHS Suffolk (12.5%) and the East of England (13.9%).

Obesity

• Childhood obesity
In the academic year 2008-09 the prevalence of obesity in children in Reception Year (ages 4-5 years) was lower in Mid Suffolk (7.6%) than in Suffolk county (8.3%; not significantly different), the East of England (8.7%; not significantly different) and England as a whole (9.6%; significantly different).

In the academic year 2008-09 the prevalence of obesity in children in Year six (ages 10-11 years) was lower in Mid Suffolk (11.8%) than in Suffolk county (15.2%; significantly different), the East of England (16.6%; significantly different) and England as a whole (18.3%; significantly different).

In essence people tend to overestimate their height and underestimate their weight.

• Adult obesity
In 2008/09 the East of England Lifestyle Survey found that 16.8% of the Mid Suffolk population (aged 16 years and older) were classified as obese or morbidly obese. This was not significantly different from the NHS Suffolk (15.7%) or the East of England (16.7%) averages.

The East of England Lifestyle Survey was administered by telephone which meant that participants’ actual height and weight was not measured. This may explain why the obesity estimates are lower than other national estimates.

Smoking

• Prevalence of smoking
In 2008 and 2009 the prevalence of smoking among adults in Mid Suffolk was 18.7%. This figure was not significantly different from the prevalence of smoking in the area covered by NHS Suffolk (18.1%) or in the East of England (18.8%).

• Deaths from smoking
Smoking is a major preventable cause of death. In 2005-07 an estimated 382 deaths among residents of Mid Suffolk aged 35 years and over were attributed to smoking. In 2005-07 the rate of smoking-attributable mortality among individuals aged 35 years and over in Mid Suffolk was significantly lower, compared to the East of England.

Hazardous and harmful drinking

In 2008 and 2009 a total of 16.1% of the population of Mid Suffolk reported hazardous and harmful levels of alcohol consumption. This figure was lower than, but not significantly different from the NHS Suffolk area (19.2%) and the East of England (20.5%).

Four healthy behaviours

In 2008 and 2009 a total of 7.6% of people aged 16 years and over in Mid Suffolk reported taking part in four healthy behaviours. These
are defined as not smoking, eating five portions of fruit and vegetables 5-7 days per week, taking the recommended level of physical exercise and not drinking more than the recommended number of alcohol units per week. This figure was higher than but not significantly different from NHS Suffolk (6.9%) and the East of England (6.7%).

**Teenage conceptions**

In 2004-06 there were 11 conceptions among girls aged under 16 years in Mid Suffolk. Fewer than 10 of these conceptions led to abortion.

Visit [www.suffolk.nhs.uk](http://www.suffolk.nhs.uk) for detailed profiles that include information on many of the social determinants of health, such as environment, economy, housing and education.

**West Suffolk MIND – Food and Mood course**

“I originally decided to go on the Food and Mood Course because my husband had a long term illness, plus anxiety and depression. Being the one who did all the shopping and cooking, I wanted to help my husband by learning how food affected his mood.

This I have done. We now eat low GI food, fruit, vegetables, wholefoods etc. We have very little sugar, very little alcohol and no caffeine.

My husband did the same course last summer and I did mine in the autumn. Our diet has changed over the months and this is much easier to deal with than all at once. Not only has my husband’s mood become more stabilised, I have also found many benefits myself. This is the first winter I can remember that I have not put on weight. Usually I put on a ½ stone or so which I try to lose in the summer by dieting).

I no longer crave cakes, biscuits, puddings and virtually never feel drawn to purchasing bought cakes or desserts.

On the course I have learnt that I was brought up to finish everything on my plate – I still have a small problem with this but overcome it by putting less on my plate in the first place, with the knowledge that I can always come back for more, which I hardly ever need to.

I used to comfort eat regularly but now view food in a different way.

We both intend to continue with our new diet and new outlook on food as we have definitely noticed the benefits.

Our sincere thanks to MIND, for all their help, guidance and understanding.”

– a happy participant
The Mid Suffolk Leisure Centre provides a wide range of activities and focuses on meeting high levels of customer care to keep customers coming back.

Both the district council and Sports and Leisure Management Ltd are committed to providing a high quality facility, with an emphasis on meeting the needs of the community, and to continue to invest in the facility.

A starting investment of approx £850,000 made a big impact upon the quality of the facilities. More recent improvements have been made to the car park and climbing facilities, with £90,000 in partnership funding.

A further £720k investment has recently been agreed which will see an extension to Stradbroke Pool to incorporate health and fitness facilities and refurbish the fitness facilities at Mid Suffolk Leisure Centre.

The health and fitness extension to Stradbroke Pool is anticipated to attract a membership of approximately 550 people, who will then exercise on a regular basis. The facility will also be able to extend their working relationship with the local GP practice, offering GP exercise referral sessions to those in need.

The current usage of both of the Council's leisure facilities is in excess of 1,000,000 visits per year.
How long do people live and what is the potential for better health?

In 2006-08 it was estimated that men live to about 80 years old and women to 84 years, which is in line with the county as a whole and with England and Wales.

In 2003-07 the difference in life expectancy at birth for men living in the most deprived parts of St Edmundsbury compared to those living in the most affluent parts of the district was 3.9 years. For women this gap in life expectancy was 2.9 years.

If 100 people lived in St Edmundsbury, then:

- 22 would be children (0 to 18 years) and 78 would be adults (19 years and above)
- Nobody would live in the most deprived areas where their health may be worse
- 9% of children aged 4 to 5 years and 17% of children aged 10 to 11 years would be overweight or obese
- 5 people aged 16 years and over would have coronary heart disease
- 3 people aged 16 years and over would have lung disease
- 49 people aged 16 years and over would take enough exercise
- 45 people aged 16 years and over would eat enough fruit and vegetables
- 19 people aged 16 years and over would smoke
- 19 people aged 16 years and over would drink too much alcohol
In the most deprived fifth of the population, reducing mortality from coronary heart disease and COPD in both sexes, other cancers and suicide in men and stroke in women, would achieve the greatest gains.

**Deaths from all causes**

A total of 2733 deaths from all causes among residents of St Edmundsbury were registered in 2006-08: an average of 911 deaths per year. In St Edmundsbury in 2006-08 there were 1308 deaths among men (47.9% of total) and 1425 deaths among women. There were 15 infant deaths (under one year of age) in St Edmundsbury in 2006-08.

**Has health improved in the last few years?**

A total of 2733 deaths from all causes among residents of St Edmundsbury were registered in 2006-08: an average of 911 deaths per year. In St Edmundsbury in 2006-08 there were 1308 deaths among men (47.9% of total) and 1425 deaths among women. There were 15 infant deaths (under one year of age) in St Edmundsbury in 2006-08.
A PROFILE OF
St Edmundsbury borough

Figure 25 shows trends in premature mortality in 1993-2008. Deaths from all causes among men aged under 75 years decreased from 451.4 deaths per 100,000 residents to 284.0: a decrease of 37.1%.

For women this rate decreased from 258.5 deaths per 100,000 residents to 180.4: a decrease of 30.2%. Mortality rates for deaths from all causes among men and women aged under 75 years were consistently lower in St Edmundsbury than in England and Wales.

What do people die of?

In St Edmundsbury in 2006-08 three main causes of death: cardiovascular disease, cancer and respiratory disease accounted for 75.4% (2054/2723) of all deaths among persons aged 28 days and over.

For men, the mortality rates for cancer, bronchitis, emphysema and COPD in St Edmundsbury were significantly lower than the rate in the East of England. The rate for cardiovascular disease was not significantly different from the East of England.

For women, the mortality rates for cancer and cardiovascular disease were not significantly different from the rates in the East of England, although the rate for COPD was significantly lower than the rate in the East of England.

What are the influences on health?

Health Poverty Index

The Health Poverty Index gives some insight into reasons why some people are healthier than others. Find out more about this by turning to the glossary. Figure 26 compares St Edmundsbury with England in 2005. Indicator scores range from 0: least health poverty (centre of chart), to 1: most health poverty (outside edge of chart). A full guide to the chart is given in the glossary.

The chart indicates that St Edmundsbury is a relatively healthy area. Scores for most indicators had better ranks than the scores for England.

St Edmundsbury performed relatively poorly for preventative care resourcing, recreation facilities and access to social care. St Edmundsbury also ranked lower than England for lifestyle, health care resourcing and health capital.

The indicator health care resourcing, which is measured as expenditure on hospital care, would necessarily be less in a district with relatively low demand for hospital services.

**Place Survey**

Another way of understanding health in an area is the Place Survey. Find out more about this by turning to the glossary. Figure 27 shows the results for St Edmundsbury from the Place Survey for 2008.

In St Edmundsbury, activities for teenagers is seen as the area in need of most improvement, although this is not considered to be among the most important issues overall.

The level of crime and health services are considered to be the most important factors by survey respondents, but are not deemed to be areas where improvement is needed.

**What is the overall level of deprivation?**

The Index of Multiple Deprivation 2007 is used as a measure of relative poverty and affluence across England (see glossary for further explanation).

Figure 28 shows this information for St Edmundsbury in comparison to Suffolk as a whole, the East of England and the whole country.

To describe the area we can also look at geographic areas (loosely equivalent to electoral wards) called lower-layer Super Output Areas or LSOAs. None of the LSOAs in St Edmundsbury was categorised among the most deprived fifth in

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Source: Place Survey (2008) Suffolk County Council
Only 10.7% of the population of St Edmundsbury lived in LSOAs in the second most deprived fifth in England. Over 64.8% of the population of St Edmundsbury lived in areas classified as “less deprived” or “least deprived”.

**Cardiovascular disease**

Cardiovascular disease includes coronary heart disease, cerebrovascular disease (stroke-related illness) and other diseases of the circulatory system.

The estimated prevalence of cardiovascular disease in 2010 is lower in St Edmundsbury than in England as a whole, but this trend is predicted to reverse in and after 2015.

Between 2010 and 2020 the estimated prevalence of cardiovascular disease among people aged 16 years and over in St Edmundsbury is projected to increase from 6.5% to 7.6%.

***What are future trends for common diseases?***

One of the consequences of the projected growth in older people across Suffolk is an increase in the diseases of older age and people suffering from long term conditions.
Coronary heart disease
The estimated prevalence of coronary heart disease is predicted to be lower in St Edmundsbury in 2010 and 2015 than England and become similar by 2020. Between 2010 and 2020 the estimated prevalence of coronary heart disease among people aged 16 years and over in St Edmundsbury is projected to increase from 5.4% to 6.2%.

Hypertension (high blood pressure)
The estimated prevalence of hypertension is higher in St Edmundsbury than in England as a whole. Between 2010 and 2020 the estimated prevalence of hypertension among people aged 16 years and over in St Edmundsbury is projected to increase from 30.6% to 33.2%.

Stroke
The estimated prevalence of stroke is higher in St Edmundsbury than in England as a whole. Between 2010 and 2020 the estimated prevalence of stroke among people aged 16 years and over in St Edmundsbury is projected to increase from 2.6% to 3.0%.

Diabetes
The estimated prevalence of diabetes is lower in St Edmundsbury than in England as a whole. Between 2010 and 2025 the estimated prevalence of diabetes among people of all ages in St Edmundsbury is projected to increase from 4.7% to 6.3%.

Chronic obstructive pulmonary (lung) disease
The estimated prevalence of chronic obstructive pulmonary disease (COPD) is lower in St Edmundsbury than in England as a whole. Between 2010 and 2025 the estimated prevalence of COPD among people aged 16 years and over in St Edmundsbury is projected to increase from 2.8% to 3.1%.

Demographic profile – Social profile of St Edmundsbury
Data shows the population of St Edmundsbury as mainly a mixture of affluent towns and villages, with affluent professionals and affluent families. This means that St Edmundsbury has a higher proportion of people on a higher income, who tend to have better health and lifestyle behaviours.

Participation in exercise
In the academic year 2007-08 a total of 94.3% of children attending state schools in St Edmundsbury belonging to the Sport Partnership, reported taking part in a minimum of two hours of quality PE and sport within the curriculum each week. This percentage was significantly higher than the percentages for Suffolk county (89.7%), the East of England (91.9%) and England as a whole (90.0%).
According to the East of England Lifestyle Survey, in 2008 and 2009 a total of 48.9% of people aged 16 years and over in St Edmundsbury reported taking the recommended level of physical activity each week. This figure was higher than but not significantly different from NHS Suffolk (45.9%) and the East of England (43.3%).

Healthy eating

In 2008 and 2009 a total of 45.4% of people aged 16 years and over in St Edmundsbury reported consuming the recommended five portions of fruit and vegetables on less than one day each week. This figure was similar to NHS Suffolk (12.5%) and lower than, but not significantly different from the East of England (13.8%).

Obesity

• Childhood obesity
In the academic year 2008-09 the prevalence of obesity in children in Reception Year (ages 4-5 years) was higher in St Edmundsbury (8.7%) than in Suffolk (8.3%; not significantly different), similar to the East of England (8.7%) and lower than England as a whole (9.6%; not significantly different).

In the academic year 2008-09 the prevalence of obesity in children in Year six (ages 10-11 years) was higher in St Edmundsbury (16.8%) than in Suffolk (15.2%; not significantly different), the East of England (16.6%; not significantly different) and lower than England as a whole (18.3%; not significantly different).

In the academic year 2008-09 totals of 14.3% of Reception Year children and 14.2% of Year six children in St Edmundsbury were recorded as overweight but not obese.

• Adult obesity
In 2008-09 the East of England Lifestyle Survey found that 15.1% of the St Edmundsbury population (aged 16 years and older) were classified as obese or morbidly obese. This was not significantly different from the NHS Suffolk (15.7%) or the East of England (16.7%) average.

The East of England Lifestyle Survey was administered by telephone which meant that participants’ actual height and weight was not measured. This may explain why the obesity estimates are lower than other national estimates. In essence people tend to overestimate their height and underestimate their weight.

Smoking

• Prevalence of smoking
In 2008 and 2009 the prevalence of smoking among adults in St Edmundsbury was 19.2%. This figure was higher than, but not significantly different from the prevalence of smoking in the area covered by NHS Suffolk (18.1%) or in the East of England (18.8%).

• Deaths from smoking
Smoking is a major preventable cause of death. In 2005-07 an estimated 439 deaths among residents of St Edmundsbury aged 35 years and over, were attributed to smoking. In 2005-07 the rate of smoking-attributable mortality among individuals aged 35 years and over in
St Edmundsbury was similar to Suffolk county and lower than, but not significantly different to the East of England.

**Hazardous and harmful drinking**

In 2008 and 2009 a total of 18.9% of the population of St Edmundsbury reported hazardous and harmful levels of alcohol consumption. This figure was lower than but not significantly different from the NHS Suffolk area (19.2%) and the East of England (20.5%).

**Four healthy behaviours**

In 2008 and 2009 a total of 6.7% of people aged 16 years and over in St Edmundsbury reported taking part in four healthy behaviours. These are defined as not smoking, eating five portions of fruit and vegetables 5-7 days per week, taking the recommended level of physical exercise and not drinking more than the recommended number of alcohol units per week. This figure was similar to NHS Suffolk (6.9%) and the East of England (6.7%).

**Teenage conceptions**

In 2005-07 there were 156 conceptions among girls aged under 18 years in St Edmundsbury. A total of 36.0% of these conceptions led to abortion. The teenage conception rate in St Edmundsbury was slightly lower than the rate for Suffolk county. Between 1998-2000 and 2005-07 the teenage conception rate in St Edmundsbury decreased by 17.0% from 34.9* conceptions to 29.0* among girls aged under 18 years (*per 1000 girls aged 15-17 years).

In 2004-06 there were 27 conceptions among girls aged under 16 years in St Edmundsbury. Eighteen of these conceptions led to abortion.

Visit [www.suffolk.nhs.uk](http://www.suffolk.nhs.uk) for a more detailed profile that includes information on many of the social determinants of health, such as physical environment, economy, housing and education.

H AVO (Haverhill Association of Voluntary Organisations) has sought out and inspired new healthy initiatives for residents.

In partnership with Haverhill Leisure Centre, HAVO hosted the annual Family Health Day in September. This successful event saw 17 stalls, including free advice, information, goody bags and tests for diabetes, blood pressure, Body Mass Index (BMI) and cholesterol. Over 88 tests were conducted with around a quarter resulting in onward referrals to GPs.

HAVO, having discovered a high demand for male MOT health checks, have worked closely with the Crown Health Centre to launch and establish a walk-in Wellman Clinic. Demand for this clinic has been so great the clinic is now available from 8am until 8pm on any day of the week! 
Health trainers

As a health trainer in Haverhill, I worked 1:1 with a mother of three, providing encouragement to lose weight and improve her health.

We set small, manageable goals for her to achieve over a period of six sessions. Her goals included reducing her intake of unhealthy snacks and swapping them for healthier choices. Other goals were to increase her activity levels and to consume more fruit and vegetable portions, gradually building up to five-a-day. Additionally, I encouraged her to take more time for herself, and to spend more time planning shopping trips and family meals. She wrote me this statement:

“I was contacted by Joan Key after she read a report I had written in the Haverhill Volunteer Centre’s annual report.

Her email read:

“I have read of health walks in other parts of Suffolk, but have never been able to find anything like them in this area. I am an overweight 72-year-old diabetic, and I know I need more exercise.

I also know that it would not be safe for me to go out walking on my own. Please can you help set up a group, with a competent leader, so that people like me can take gentle exercise, to improve not only our health, but also our social life.”

– Joan Key, Haverhill

On receiving this email, a meeting was arranged with Suffolk Coastal district, which spearheads the health walks in the county, to set-up the healthy walking scheme in Haverhill. I also spoke to community members to see what they wanted from a healthy walking group. The end result is that Haverhill has now had two successful community health walks in the town which will continue to grow - and Joan Key is now a qualified volunteer walk leader.

Case study 2

St Nicholas Hospice

Helping people return to work through volunteering in the hospice’s retail centre.

This has been achieved in partnership with:

• Suffolk County Council’s Adult Community Services – encouraging people with learning disabilities.
• Volunteer Centre – Working with two different groups; some people with learning disabilities, others with mental health issues.
• YMCA/JobcentrePlus – implementing the government scheme which encourages people back to work through experience in the voluntary sector.

The people involved, work in groups, on various projects with the constant support and supervision from paid staff. Feedback has been fulsome and encouraging.

Vivien Anderson, Volunteer Manager

Case study 3

“Visiting a health trainer gave me the personal motivation that I had been unable to find and to lose weight for me!

The entire process helped me identify my weaknesses with food and empowered me to change a few things to improve my diet. I now weigh less and look and feel better than I have in ages.

Thank you Hatty for your tips and positive thinking, you are a very motivating individual”

– Tracie Creffield, Bury St Edmunds
How long do people live and what is the potential for better health?

In 2006-08 it was estimated that men live to about 81 years old and women to 84 years, which is slightly higher than the county as a whole and England and Wales.

In 2003-07 the difference in life expectancy at birth for men living in the most deprived parts of Suffolk Coastal compared to those living in the most affluent parts of the district was 3.9 years. For women this gap in life expectancy was 3.1 years.

If 100 people lived in Suffolk Coastal, then:

22 would be children (0 to 18 years) and 78 would be adults (19 years and above)
Nobody would live in the most deprived areas where their health may be worse
8% of children aged 4 to 5 years and 14% of children aged 10 to 11 years would be overweight or obese
6 people aged 16 years and over would have coronary heart disease
3 people aged 16 years and over would have lung disease
44 people aged 16 years and over would take enough exercise
50 people aged 16 years and over would eat enough fruit and vegetables
12 people aged 16 years and over would smoke
22 people aged 16 years and over would drink too much alcohol
Figure 29

Years of life expectancy gained if the most deprived fifth of the population in Suffolk Coastal had the same mortality rates as the least deprived fifth.

Deaths from selected causes. Residents of Suffolk Coastal district 2001-05

Reducing mortality from coronary heart disease, lung cancer, suicide and ill defined conditions in men, in the most deprived fifth of the population would achieve the greatest gains. In the same group, reducing deaths from coronary heart disease, pneumonia and some digestive diseases in women would make a difference.

Has health improved in the last few years?

A total of 3982 deaths from all causes among residents of Suffolk Coastal district were registered in 2006-08: an average of 1327 deaths per year. In Suffolk Coastal in 2006-08 there were 1860 deaths among men (46.7% of total) and 2122 deaths among women. There were 12 infant deaths (under one year of age) in Suffolk Coastal in 2006-08.

Figure 30 shows trends in premature mortality in 1993-2008. Deaths from all causes among men aged under 75 years decreased from 408.2 deaths per 100,000 residents to 251.8: a decrease of 38.3%. For women this rate decreased from 225.5 deaths per 100,000 residents to 178.8: a decrease of 20.7%.

Mortality rates for deaths from all causes among men and women aged under 75 years were consistently lower in Suffolk Coastal than in England and Wales.

**What do people die of?**

In Suffolk Coastal in 2006-08 three main causes of death: cardiovascular disease, cancer and respiratory disease accounted for 77.1% (3066/3975) of all deaths among persons aged 28 days and over.

For men, the mortality rates for cancer, bronchitis, emphysema and COPD in Suffolk Coastal were significantly lower than the rate in the East of England. The mortality rate for cardiovascular disease was not significantly different from the East of England.

For women, the mortality rates for cancer and cardiovascular disease were not significantly different from the East of England. The mortality rate for COPD was significantly lower than the rates in the East of England.
What are the influences on health?

Health Poverty Index

The Health Poverty Index gives some insight into reasons why some people are healthier than others. Find out more about this by turning to the glossary. Figure 31 compares Suffolk Coastal with England in 2005. Indicator scores range from 0: least health poverty (centre of chart), to 1: most health poverty (outside edge of chart). A full guide to the chart is given in the glossary.

The chart indicates that Suffolk Coastal is a relatively healthy area. Scores for most indicators had better ranks than the scores for England. Suffolk Coastal performed relatively poorly for access to secondary care, access to social care and health capital. Suffolk Coastal also had worse ranks than England for local government resourcing and health care resourcing.

The indicator for health capital measures an individual’s potential for health across the life course. The components of this indicator include low birthweight and modelled estimates of blood pressure, cholesterol and obesity.

The relatively poor score for health capital in Suffolk Coastal may reflect the fact that the population of the district includes relatively high percentages of middle-aged and elderly persons.

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Place Survey

Another way of understanding health in an area is the Place Survey. Find out more about this by turning to the glossary. Figure 32 shows the results for Suffolk Coastal from the Place Survey for 2008.

In Suffolk Coastal, activities for teenagers and road and pavement repairs are seen as the areas in need of most improvement, although they are not considered to be among the most important issues overall.

The level of crime and health services are considered to be the most important factors by survey respondents, but are not deemed to be areas where improvement is needed.

What is the overall level of deprivation?

The Index of Multiple Deprivation 2007 is used as a measure of relative poverty and affluence across England (see glossary for further explanation).

Figure 33 shows this information for Suffolk Coastal in comparison to Suffolk as a whole, the East of England and the whole country.

To describe the area we can also look at geographic areas (loosely equivalent to electoral wards) called lower-layer Super Output Areas or LSOAs. None of the LSOAs in Suffolk Coastal was categorised among the most deprived fifth in England.

Source: Place Survey (2008) Suffolk County Council
Only 5.0% of the population of Suffolk Coastal lived in LSOAs in the second most deprived fifth in England. Over 68% of the population of Suffolk Coastal lived in areas classified as “less deprived” or “least deprived”.

What are future trends for common diseases?

One of the consequences of the projected growth in older people across Suffolk is an increase in the diseases of older age and people suffering from long term conditions.

Cardiovascular disease

Cardiovascular disease includes coronary heart disease, cerebrovascular disease (stroke-related illness) and other diseases of the circulatory system.

The estimated prevalence of cardiovascular disease is higher in Suffolk Coastal than in England as a whole. Between 2010 and 2020 the estimated prevalence of cardiovascular disease among people aged 16 years and over in Suffolk Coastal is projected to increase from 7.5% to 8.6%.

Coronary heart disease

The estimated prevalence of coronary heart disease is predicted to be higher in Suffolk Coastal than in England as a whole. Between 2010 and 2020 the estimated prevalence of coronary heart disease, cerebrovascular disease (stroke-related illness) and other diseases of the circulatory system.
disease among people aged 16 years and over in Suffolk Coastal is projected to increase from 6.2% to 7.0%.

**Stroke**
The estimated prevalence of stroke is higher in Suffolk Coastal than in England as a whole. Between 2010 and 2020 the estimated prevalence of stroke among people aged 16 years and over in Suffolk Coastal is projected to increase from 2.9% to 3.3%.

**Chronic obstructive pulmonary (lung) disease**
The estimated prevalence of chronic obstructive pulmonary disease (COPD) is lower in Suffolk Coastal than in England as a whole. Between 2010 and 2020 the estimated prevalence of COPD among people aged 16 years and over in Suffolk Coastal is projected to increase from 2.8% to 3.1%.

**Hypertension (high blood pressure)**
The estimated prevalence of hypertension is higher in Suffolk Coastal than in England as a whole. Between 2010 and 2020 the estimated prevalence of hypertension among people aged 16 years and over in Suffolk Coastal is projected to increase from 33.6% to 36.1%.

**Diabetes**
The estimated prevalence of diabetes is higher in Suffolk Coastal than in the East of England and England as a whole. Between 2010 and 2025 the estimated prevalence of diabetes among people of all ages in Suffolk Coastal is projected to increase from 5.4% to 7.3%.

**What sort of lifestyles do people have?**
This section includes information on the demographic profile, participation in exercise, healthy eating, obesity, smoking and alcohol misuse, four healthy behaviours, and teenage conceptions.

**Demographic profile – Social profile of Suffolk Coastal**
Data shows the population of Suffolk Coastal as mainly a mixture of affluent towns and villages, affluent professionals, and home-owning older couples.

In comparison to Suffolk county, Suffolk Coastal has a higher percentage of affluent healthy pensioners, affluent professionals and home-owning older couples, which means there is a higher proportion of well-off people who tend to have better health and lifestyle behaviours. Potential problems may include a relatively high level of both alcohol consumption and dining out.

In comparison to Suffolk county, Suffolk Coastal has lower percentages of disadvantaged multi-ethnic younger adults.

Further detail is available in the full profile on the internet at: www.suffolk.nhs.uk.

**Participation in exercise**
In the academic year 2007-08 a total of 84.8% of children attending state schools in Suffolk Coastal belonging to the Sport Partnership, reported taking part in a minimum of two hours of quality PE and sport within the curriculum each week. This percentage was significantly lower than the percentages for Suffolk county (89.7%), the East of England (91.9%) and England as a whole (90.0%).

According to the East of England Lifestyle Survey, in 2008 and 2009 a total of 44.0% of people aged
16 years and over in Suffolk Coastal reported taking the recommended level of physical activity each week. This figure was lower than, but not significantly different from NHS Suffolk (45.9%) and similar to the East of England (43.3%).

Healthy eating

In 2008 and 2009 a total of 49.7% of people aged 16 years and over in Suffolk Coastal reported consuming the recommended five portions of fruit and vegetables on 5-7 days per week. This figure was significantly higher than the value for NHS Suffolk (43.6%) and the East of England (41.8%).

Obesity

• Childhood obesity
  In the academic year 2008-09 the prevalence of obesity in children in Reception Year (ages 4-5 years) was lower in Suffolk Coastal (7.6%) than in Suffolk county (8.3%; not significantly different), the East of England (8.7%; not significantly different) and England as a whole (9.6%; significantly different).

• Adult obesity
  In the academic year 2008-09 the prevalence of obesity in children in Year 6 (ages 10-11 years) was lower in Suffolk Coastal (13.6%) than in Suffolk county (15.2%; not significantly different), the East of England (16.6%; not significantly different) and England as a whole (18.3%; significantly different).

In the academic year 2008-09 totals of 13.6% of Reception Year children and 12.5% of Year 6 children in Suffolk Coastal were recorded as overweight but not obese.

Smoking

• Prevalence of smoking
  In 2008 and 2009 the prevalence of smoking among adults in Suffolk Coastal was 12.0%. This figure was significantly lower than the prevalence of smoking in the East of England (16.7%) average.

The East of England Lifestyle Survey was administered by telephone which meant that participants’ actual height and weight was not measured.

This may explain why the obesity estimates are lower than other national estimates. In essence people tend to overestimate their height and underestimate their weight.

Deaths from smoking

Smoking is a major preventable cause of death. In 2005-07 an estimated 560 deaths among residents of Suffolk Coastal aged 35 years and over were attributed to smoking. In 2005-07 the rate of smoking-attributable mortality among individuals aged 35 years and over in Suffolk Coastal (146.1 deaths per 100,000) was significantly low compared to the East of England.

Hazardous and harmful drinking

In 2008 and 2009 a total of 22.1% of the population of area covered by NHS Suffolk (18.1%) or in the East of England (18.8%).
Suffolk Coastal reported hazardous and harmful levels of alcohol consumption. This figure was higher than, but not significantly different from the NHS Suffolk area (19.2%) and the East of England (20.5%).

**Four healthy behaviours**

In 2008 and 2009 a total of 8.4% of people aged 16 years and over in Suffolk Coastal reported taking part in four healthy behaviours. These are defined as not smoking, eating five portions of fruit and vegetables 5-7 days per week, taking the recommended level of physical exercise and not drinking more than the recommended number of alcohol units per week. This figure was higher than, but not significantly different from NHS Suffolk (6.9%) and the East of England (6.7%).

**Teenage conceptions**

In 2005-07 there were 158 conceptions among girls aged under 18 years in Suffolk Coastal. A total of 46.0% of these conceptions led to abortion. The teenage conception rate in Suffolk Coastal is relatively low and decreasing. Between 1998-2000 and 2005-07 the teenage conception rate in Suffolk Coastal decreased by 12.2% from 25.2* conceptions to 22.1* among girls aged under 18 years (*per 1000 girls aged 15-17 years).

In 2004-06 there were 26 conceptions among girls aged under 16 years in Suffolk Coastal. Fewer than 13 of these conceptions led to abortion.

Visit [www.nhs.suffolk.uk](http://www.nhs.suffolk.uk) for a more detailed profile that includes information on many of the social determinants of health, such as physical environment, economy, housing and education.

**Case study 1**

**Yoxmere Benefice Parish Nurses**

The Yoxmere Benefice Parish Nurse and Support Group work out of the churches to provide a service to all those who live within the boundaries of the benefice.

Local health issues in this isolated rural area, with its largely elderly population include mental health issues, mobility problems, respite care needs and loneliness. The group has organised volunteers to run many health initiatives, such as: exercise and falls prevention classes, lunch clubs, social clubs for those with dementia and their carers. It also has a bath rota, where those living on their own can have a volunteer sit with them while they have a bath so that they know there is someone there to call on if they get into difficulty.

This project has been successful because it is run by local people who are well placed to respond quickly to a wide range of needs.
The Suffolk Coastal community safety partnership (CSP) worked with a number of local agencies to hold a series of alcohol awareness workshops for young people in schools across the district. Questionnaires completed before and after each session showed a significant improvement in young people’s knowledge about alcohol, particularly the number of units contained in alcoholic drinks.

Multi-partnership working proved successful in highlighting the impact alcohol misuse can have on health and wellbeing. Both young people and teachers were positive about the workshops, praising them as easy to understand and communicating hard-hitting truths. They were also keen to participate in future drug and substance misuse events.

Road shows providing information and advice on alcohol and drug misuse to all members of the community have subsequently been held.

Operation Camouflage has taken place for the past two years. Many of the young people previously involved in anti-social behaviour showed a great improvement in behaviour and engaged in positive activities after attending the activity camp.

One of the young people attending Operation Camouflage 2009 continued to work well with additional support from youth workers after the project, achieving significant positive improvements. The individual’s school attendance and participation in extra curricular activities increased considerably, and they no longer engaged in anti-social behaviour. This individual has been invited back to Operation Camouflage 2010 to help out as part of the staff, offering support and positive guidance to young people who may have a similar background. It is hoped that they will also become an ambassador for the project.

Operation Camouflage is a five day activity camp organised by the Suffolk Coastal community safety partnership (CSP). Based at the Rock Barracks, home of the 23rd Engineer Regiment (Air Assault), near Woodbridge, the fun filled activity camp helps to give young people a long-term interest in keeping active and leading a healthier lifestyle. It also aims to reduce anti-social behaviour.

It is open to all young people in the district with 15 spaces reserved for young people who have recently committed anti-social behaviour or have been identified as being at risk of offending.

Case study 2

**Operation Camouflage**

Fun and interaction was used to engage participants. Activities included:
- a units quiz and beer goggles game by the CSP
- a legalities quiz by the police
- information about drunk driving by the fire service
- role play scenarios by school nurses, themed around sexual health and alcohol
- a smoothie stall with healthy alternatives to alcoholic drinks by the Co-op
- personal accounts about alcohol misuse and out of control drinking by Alcoholics Anonymous
- discussions about the impact of alcohol misuse in the family by Local Youth Work Teams
- alcohol poisoning and emergency first aid sessions by an independent drugs trainer
- awareness session on personal safety for young people out clubbing or drinking in the street by local town pastors.

Case study 3

**Alcohol awareness and information sessions**

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Multi-partnership working proved successful in highlighting the impact alcohol misuse can have on health and wellbeing. Both young people and teachers were positive about the workshops, praising them as easy to understand and communicating hard-hitting truths. They were also keen to participate in future drug and substance misuse events.

Road shows providing information and advice on alcohol and drug misuse to all members of the community have subsequently been held.
How long do people live and what is the potential for better health?

In 2006-08 it was estimated that men live to about 79 years old and women to 83 years, which is in line with the county as a whole and with England and Wales.

In 2003-07 the difference in life expectancy at birth for men living in the most deprived parts of Waveney compared to others living in the most affluent parts of the district was 9.6 years. For women this gap in life expectancy was 6.4 years.

If 100 people lived in Waveney, then:

- 21 would be children (0 to 18 years) and 79 would be adults (19 years and above)
- 15 would live in the most deprived areas where their health may be worse
- 9% of children aged 4 to 5 years and 18% of children aged 10 to 11 years would be overweight or obese
- 8 people aged 16 years and over would have coronary heart disease
- 4 people aged 16 years and over would have lung disease
- 44 people aged 16 years and over would take enough exercise
- 43 people aged 16 years and over would eat enough fruit and vegetables
- 20 people aged 16 years and over would smoke
- 18 people aged 16 years and over would drink too much alcohol
Figure 34

Years of life expectancy gained if the most deprived fifth of the population in Waveney had the same mortality rates as the least deprived fifth.

Deaths from selected causes. Residents of Waveney district 2001-05

Reducing mortality from coronary heart disease, suicide, other accidents and lung cancer in men in the most deprived fifth of the population would achieve the greatest gains. In the same group, reducing mortality from COPD in women would make a difference.

Has health improved in the last few years?

Deaths from all causes

A total of 4199 deaths from all causes among residents of Waveney were registered in 2006-08: an average of 1400 deaths per year. In Waveney in 2006-08 there were 1993 deaths among men (47.5% of total) and 2206 deaths among women. There were 13 infant deaths (under one year of age) in Waveney in 2006-08.
Figure 35 shows trends in premature mortality in 1993-2008. Deaths from all causes among men aged under 75 years decreased from 464.4 deaths per 100,000 residents to 331.7: a decrease of 28.6%. For women this rate decreased from 286.5 deaths per 100,000 residents to 218.4: a decrease of 23.8%.

**What do people die of?**

Mortality rates for deaths from all causes among women aged under 75 years have increased slightly in recent years although the rates among men and women were still consistently lower in Waveney than in England and Wales.

In Waveney in 2006-08 three main causes of death: cardiovascular disease, cancer and lung disease, accounted for 74.1% (3102/4188) of all deaths among people aged 28 days and over.

For men, the mortality rates for malignant cancers, cardiovascular diseases, bronchitis, emphysema and COPD in Waveney were not significantly different from the rate in the East of England.

For women, the mortality rates for malignant cancers, cardiovascular diseases and COPD were not significantly different from the rates in the East of England.

**Figure 35**


Source: Data: NHS Clinical and Health Outcomes Knowledge Base (2010) Mortality from all causes. NHS Information Centre (http://www.nchodo.nhs.uk accessed 14 April 2010); Graph: Department of Public Health, NHS Suffolk
What are the influences on health?

**Health Poverty Index**

The Health Poverty Index gives some insight into reasons why some people are healthier than others. Find out more about this by turning to the glossary. Figure 36 compares Waveney with England in 2005. Indicator scores range from 0: least health poverty (centre of chart), to 1: most health poverty (outside edge of chart).

The chart for Waveney indicates areas of relative health poverty in the district. Outliers, where Waveney performed relatively poorly, include change in job supply, income, wealth, human capital, recreation facilities, access to social care, psychological morbidity, health capital and physical morbidity. Waveney was also ranked worse than England for Gross Value Added per capita, lifestyle, home environments, work and local environments, health care resourcing and premature mortality.

Health poverty in Waveney occurs mainly in the domains of regional prospects, household conditions, behaviours and environments and health status. The chart indicates that, in particular, Waveney has relatively good health care and good educational quality.

Another way of understanding health in an area is the Place Survey. Find out more about this by turning to the glossary. Figure 37 shows the results for Waveney from the Place Survey for 2008.

In Waveney, activities for teenagers, job prospects and traffic congestion are considered to be the areas most in need of improvement, although they are not among the most important issues overall. The level of crime and health services are considered to be the most important issues by survey respondents, but are not thought to be in particular need of improvement.

The Index of Multiple Deprivation 2007 is used as a measure of relative poverty and affluence across England (see glossary for further explanation).

Figure 38 shows this information for Waveney in comparison to Suffolk as a whole, the East of England and the whole country.

To describe the area we can also look at geographic areas (loosely equivalent to electoral wards) called lower-layer Super Output Areas or LSOAs. Around 15% of the population of Waveney lived in LSOAs in the most deprived fifth in England. Around 24% of the population of Suffolk lived in LSOAs in the most deprived fifth in England.

Source: Place Survey (2008) Suffolk County Council
population of Waveney lived in LSOAs in the second most deprived fifth in England. Over 26% of the population of Waveney lived in areas classified as “less deprived” or “least deprived”.

What are future trends for common diseases?

One of the consequences of the projected growth in older people across Suffolk is an increase in the diseases of older age and people suffering from long term conditions.

**Cardiovascular disease**

Cardiovascular disease includes coronary heart disease, cerebrovascular disease (stroke-related illness) and other diseases of the circulatory system.

The estimated prevalence of cardiovascular disease is higher in Waveney than in England as a whole. Between 2010 and 2020 the estimated prevalence of cardiovascular disease among people aged 16 years and over in Waveney is projected to increase from 9.1% to 10.4%.

**Coronary heart disease**

The estimated prevalence of coronary heart disease is higher in Waveney than in England as a whole. Between 2010 and 2020 the estimated prevalence of coronary heart disease among people aged 16 years and over in Waveney is projected to increase from 7.9% to 8.9%.
Stroke
The estimated prevalence of stroke is higher in Waveney than in England as a whole. Between 2010 and 2020 the estimated prevalence of stroke among people aged 16 years and over in Waveney is projected to increase from 3.3% to 3.8%.

Hypertension (high blood pressure)
The estimated prevalence of hypertension is higher in Waveney than in England as a whole. Between 2010 and 2020 the estimated prevalence of hypertension among people aged 16 years and over in Waveney is projected to increase from 36.5% to 39.0%.

Chronic obstructive pulmonary (lung) disease
The estimated prevalence of chronic obstructive pulmonary disease (COPD) is higher in Waveney than in England as a whole. Between 2010 and 2020 the estimated prevalence of COPD among people aged 16 years and over in Waveney is projected to increase from 4.1% to 4.4%.

Diabetes
The estimated prevalence of diabetes is higher in Waveney than in England as a whole. Between 2010 and 2025 the estimated prevalence of diabetes among people of all ages in Waveney is projected to increase from 5.9% to 7.8%.

What sort of lifestyles do people have?
This section includes information on the demographic profile, participation in exercise, healthy eating, obesity, smoking and alcohol misuse, four healthy behaviours, and teenage conceptions.

Demographic profile – Social profile of Waveney
Data shows the population of Waveney as mainly a mixture of average to affluent towns and villages, and home owning older couples.

In comparison to Suffolk, Waveney has a higher percentage of home owning pensioners, older couples and elderly people with associated health issues. There are a lower proportion of students and young professionals.

Further detail is available in the full profile on the internet at: www.suffolk.nhs.uk.

Participation in exercise
In the academic year 2007-08 a total of 89.7% of children attending state schools in Waveney belonging to the Sport Partnership, reported taking part in a minimum of two hours of quality PE and sport within the curriculum each week. This percentage was not statistically significant compared to the percentages for Suffolk county (89.7%) and England as a whole (90.0%). However, this percentage was significantly lower than the percentage for the East of England (91.9%)

According to the East of England Lifestyle Survey, in 2008 and 2009 a total of 44.0% of people aged 16 years and over in Waveney reported taking the recommended level of physical activity each week. This figure was not significantly different from NHS Suffolk (45.9%) and the East of England (43.3%).

Healthy eating
In 2008 and 2009 a total of 42.6% of people aged 16 years and over in Waveney reported consuming the recommended five portions...
of fruit and vegetables on 5-7 days per week. This figure was not significantly different from NHS Suffolk (43.6%) and the East of England (41.8%).

In 2008 and 2009 a total of 14.5% of people aged 16 years and over in Waveney reported consuming five portions of fruit and vegetables on less than one day each week. This figure was higher than, but not significantly different from NHS Suffolk (12.5%) and the East of England (13.9%).

**Obesity**

- **Childhood obesity**
  
  In the academic year 2008-09 the prevalence of obesity in children in Reception Year (ages 4-5 years) was higher in Waveney (9.1%) than in Suffolk (8.3%; not significantly different), the East of England (8.7%; not significantly different) but lower than in England as a whole (9.6%; not significantly different).

  In the academic year 2008-09 the prevalence of obesity in children in Year six (ages 10-11 years) was higher in Waveney (18.4%) than in Suffolk (15.2%; significantly different), the East of England (16.6%; not significantly different) and England as a whole (18.3%; not significantly different).

- **Adult obesity**
  
  In 2008-09 the East of England Lifestyle Survey found that 17.8% of the Waveney population (aged 16 years and older) were classified as obese or morbidly obese. This was not significantly different from the East of England (16.7%) average.

  The East of England Lifestyle Survey was administered by telephone which meant that participants’ actual height and weight was not measured. This may explain why the obesity estimates are lower than other national estimates. In essence people tend to overestimate their height and underestimate their weight.

**Smoking**

- **Prevalence of smoking**
  
  In 2008 and 2009 the prevalence of smoking among adults in Waveney was 19.8%. This figure was not significantly different from the prevalence of smoking in the area covered by NHS Suffolk (18.1%) or in the East of England (18.8%).

- **Deaths from smoking**
  
  Smoking is a major preventable cause of death. In 2005-07 an estimated 669 deaths among residents of Waveney aged 35 years and over were attributed to smoking. In 2005-07 the rate of smoking-attributable mortality among individuals aged 35 years and over in Waveney: 189.0 deaths per 100,000, was higher, but not statistically significantly higher, than the rates in Suffolk county and the East of England.

- **Hazardous and harmful drinking**
  
  In 2008 and 2009 a total of 18.2% of the population of Waveney reported hazardous and harmful levels of alcohol consumption. This figure was lower than, but not significantly different from the NHS Suffolk area (19.2%) and the East of England (20.5%).

**Four healthy behaviours**

In 2008 and 2009 a total of 6.4% of people aged 16 years and over in Waveney reported taking part in four healthy behaviours. These are defined as not smoking,
eating five portions of fruit and vegetables 5-7 days per week, taking the recommended level of physical exercise and not drinking more than the recommended number of alcohol units per week.

This figure was lower than, but not significantly different from NHS Suffolk (6.9%) and the East of England (6.7%).

**Teenage conceptions**

In 2005-07 there were 292 conceptions among girls aged under 18 years in Waveney. A total of 39% of these conceptions led to abortion.

Visit [www.suffolk.nhs.uk](http://www.suffolk.nhs.uk) for a more detailed profile that includes information on many of the social determinants of health, such as physical environment, economy, housing and education.


**Case study**

### Out and About

Out and About is a charity which enables disabled children and young people to access everyday leisure facilities in Suffolk and throughout the East of England.

By supporting disabled children and young people in mainstream leisure activities of their choice, their physical and emotional health needs are being addressed and improved. An example of this includes children with complex physical needs being supported in swimming sessions. This builds on the physiotherapy that the children receive and helps to maintain their muscle strength and mobility. Other children take part in sports activities such as trampolining and football, which increases their overall fitness and helps to prevent childhood obesity.

In addition, many of the children that we support have low self-esteem and lack confidence. By giving the young people support to access the same leisure activities as their non-disabled peers, their emotional health and wellbeing is enhanced as they gain a sense of achievement and self worth.
Case study 1

Disability Sports Forum Launch

Thursday 3rd December 2009 marked 1,000 days to the Paralympics in London. To celebrate this date, which also coincided with the International Day of Persons with Disabilities, the Active Waveney Sports Partnership launched a new Disability Sports Forum at Waterlane Leisure Centre, Lowestoft.

The forum aims to promote disability sporting opportunities in the Waveney area. The event ‘kicked-off’ with demonstration sports including judo, football and table tennis and brought together key people for the inaugural meeting of the Active Waveney Disability Sports Forum.

The key objectives of the forum are:

- To raise the profile and provide a voice for disability sport in Waveney and act as an effective communication network across the district.
- Through collaborative working, to ensure that there is a cohesive approach, working with existing and new partners and developing stronger relationships with other partners within the disability sport sector.
- To increase participation levels within disability sport in Waveney.
- To promote the wider community benefits of disability sport.
- To enhance the delivery of disability sport and physical activity in Waveney by creating a partnership approach to the development and delivery of sport and physical activity projects and programmes.
- To facilitate access to resources including funding, and provide guidance and advice.
- To act as a consultation platform for the district.
- To share information and best practice.
Case study 2

Community nutrition team

The community nutrition team provide weight management support and health promotion advice across a range of initiatives, including community cooks and ‘joy of food’ programmes.

It has undertaken numerous initiatives targeting school children, providing weight management support, improving diet and increasing physical activity, including:

- HENRY, three tiered healthy lifestyle programme to promote healthy weight for 108 children aged 0-4 years and their families in the Waveney area.
- MEND, targeting 200 families with children aged 7-13 years who are overweight or obese registered in the Great Yarmouth and Waveney PCT area, using social marketing profiles to help with recruitment of families, providing tailored support to increase exercise and improve diet and nutrition.
- Active8IT plus, primary prevention package aimed at children aged 7-13 years.
- Commissioning a height and weight team to support school health services to support delivery of the National Child Measurement Programme.
- Teen weight management and maintenance programme for young people aged 13 -17 years registered in the NHS Great Yarmouth and Waveney area, targeting any young person who has a BMI over the 91st centile.
- Young Person’s Exercise coordinator service, to deliver targeted programme of physical activity in schools and early years community groups in our most deprived MSOAs to increase physical activity by children aged 5-12 years.
- Engaged with local authority and local ‘play partnership’ to ensure that play and open spaces strategies promote health benefits and form part of our strategies to reduce obesity.
Acknowledgements  I would like to thank all of the contributors to this report, in particular Mid Suffolk District Council and University Campus Suffolk, as well as those who directly helped its production. Additionally, my thanks go to the many colleagues, community groups and voluntary agencies that commented on the text and provided invaluable feedback.
Age-standardisation: a procedure for adjusting rates, designed to minimise the effects of differences in age composition when comparing rates for different populations. 

Age-standardised mortality rates: are calculated to compensate for the fact that men and women have different death rates that also vary by age. Age standardisation allows valid comparison of mortality rates in different populations with different age distributions.

Body mass index (BMI): is a simple index of weight-for-height that is commonly used in classifying overweight and obesity in adult populations and individuals. It is defined as the weight in kilograms divided by the square of the height in metres. (World Health Organisation)

Bronchitis: means ‘inflammation of the bronchi’. These are the tubes or airways which carry oxygen from the air through the lungs. This inflammation increases mucus production in the airways, producing phlegm which makes you cough. (British Lung Foundation)

Cardiovascular disease: a term used to describe a variety of heart diseases, illnesses, and events that impact the heart and circulatory system, including high blood pressure and coronary artery disease. (British Heart Foundation)

Cerebrovascular disease: any disease that affects an artery within the brain, or supplies blood to the brain. (NHS Choices)

Chronic obstructive airways disease: any of a group of progressive respiratory disorders where someone experiences loss of lung function and shows little or no response to drug treatments. (British Lung Foundation)

Chronic obstructive pulmonary disease: chronic obstructive pulmonary disease (COPD) refers to a group of lung diseases that block airflow and make it increasingly difficult for you to breathe. (British Lung Foundation)

Cirrhosis of the liver: cirrhosis is scarring of the liver that involves the formation of fibrous (scar) tissue associated with the destruction of the normal architecture of the organ. (Patient UK)

Colorectal cancer: cancer of the bowel. (Cancer Research UK)

Congenital anomalies: birth defects are also called “congenital abnormalities” or “congenital abnormalities.” The word “congenital” means “present at birth.” The words “anomalies” and “abnormalities” mean that there is a problem present in a baby.

Coronary heart disease (CHD): develops when the arteries supplying blood to the heart becomes partially or wholly blocked. It’s often caused by fatty deposits building up on the inside lining of the arteries. This causes symptoms of chest pain, which is temporary and treatable. CHD can result in a heart attack if the blood supply to the heart is stopped for long enough to cause damage. (NHS Choices)

Deprivation: relates to poverty, disadvantage and ill health. Currently deprivation is measured by the English Indices of Deprivation 2007 (ID 2007). In ID 2007 deprivation at a local level is measured by an Index of Multiple Deprivation (IMD 2007) which includes seven categories measuring different types of deprivation.

Diabetes: is a common life-long condition where the amount of glucose in the blood is too high as the body cannot use it properly. This is because the pancreas does not produce any or not enough insulin, or the insulin that is produced doesn’t work properly. (Diabetes UK)

Disease projections: projections of the future prevalence of disease, or the predicted numbers of cases of disease in the population at particular future time points. The projections are based on statistical models which take account of such factors as age, sex, ethnicity, smoking status and deprivation.
Duodenum ulcer: an ulcer is a sore or a hole that forms in the lining of the stomach or small intestine (duodenum). (Patient UK)

Emphysema: this is where the alveoli (air sacs) in the lungs lose their elasticity. This reduces the support of the airways, causing them to narrow. It also means the lungs are not as good at getting oxygen into the body, so you may have to breathe harder. This can result in shortness of breath. (British Lung Foundation)

Endocrine, nutritional and metabolic diseases: diseases concerning the body’s metabolism and related conditions, for example diabetes, thyroid disease.

Genitourinary disease: these are conditions usually caused by infections that can affect the genital area and urinary system. (Patient UK)

Harmful drinking: is defined as consumption of 22-50 units of alcohol per week by men and 15-35 units per week by women.

Hazardous drinking: is defined as consumption of 51 or more units of alcohol per week by men and 36 or more units per week by women.

Health inequalities: can be defined as differences in health status or in the distribution of health determinants between different population groups. (World Health Organisation)

Health Poverty Index (HPI): is a tool covering all local authority districts in England. It allows geographical areas and different ethnic groups to be compared in terms of their ‘health poverty’. It provides a single, high level, visual summary of an area’s status in terms of health poverty drawing on over 60 indicators of health and its wider determinants. (http://www.hpi.org.uk) See a more detailed explanation at the end of the glossary.

Heart failure: is the term used when the heart becomes less efficient at pumping blood around the body, either while you are resting or active. (British Heart Foundation)

Index of Multiple Deprivation: deprivation relates to poverty, disadvantage and ill health. Currently deprivation is measured by the English Indices of Deprivation 2007 (ID 2007). In ID 2007 deprivation at a local level is measured by an Index of Multiple Deprivation (IMD 2007) and seven domains measuring different types of deprivation, as follows:

- Income Deprivation Domain
- Employment Deprivation Domain
- Health Deprivation and Disability Domain
- Education, Skills and Training Deprivation Domain
- Barriers to Housing and Services Domain
- Crime Domain
- Living Environment Deprivation Domain

IMD 2007 combines data from the seven deprivation domains to produce an overall index of deprivation. Data from IMD 2007 are presented in the deprivation graph in the district health profiles in this report.

Life expectancy at birth: the average number of years a newborn baby is expected to live if current mortality trends continue to apply. It is important to note that a life expectancy at birth of 80 years does not mean than someone born today can, on average, expect to live 80 years (in fact, they can expect to live longer if mortality rates continue to fall). It is legitimate to say however, that a population with a life expectancy of 80 years is healthier (or at least has lower mortality) than a population with one of 70 years.

Lower-layer Super Output Areas (LSOAs): are small geographic areas used in England and Wales developed by the Office for National Statistics. LSOAs have a minimum population of 1000 people and a mean population of 1500 people. Suffolk county is divided into 426 LSOAs.

Mean: in statistics, the mean is the mathematical average of a set of numbers.

Mortality rate: a calculation of the proportion of a population that dies during a specified period.
Musculoskeletal diseases: diseases of the muscles and their associated ligaments and other connective tissue and of the bones and cartilage viewed collectively.

Oesophageal cancer: cancer of the gullet or food pipe (oesophagus). (Cancer Research UK)

Overweight and obesity: the prevalence of overweight and obesity is commonly assessed by using body mass index (BMI), defined as the weight in kilograms divided by the square of the height in metres (kg/m²). A BMI over 25 kg/m² is defined as overweight, and a BMI of over 30 kg/m² as obese. (World Health Organisation)

Perinatal conditions: diseases and illnesses that occur during the period closely surrounding birth.

Place Survey: is a survey of local people’s views, experiences and perceptions about how well government priorities are being delivered by local government and local government partnerships. The Place Survey includes questions on the following topics:
- About your local area
- Your local public services
- Information
- Local decision-making
- Helping out
- Getting involved
- Respect and consideration
- Community safety
- About yourself

The charts in the section on the Place Survey in the district health profiles summarise results from the Suffolk County Council Place Survey for 2008.

Pneumonia: is inflammation (swelling) of the tissues in one or both of your lungs. It is usually caused by an infection. At the end of the airways in your lungs there are clusters of tiny air sacs called alveoli. If you have pneumonia, these tiny sacs become inflamed and fill up with fluid. As well as making you cough, the inflammation makes it harder for you to breathe. It also means your body is less able to absorb oxygen. (NHS Choices)

Premature mortality: is defined as deaths occurring before age 75 years.

Quintiles: are values that divide a sample of data into five groups containing (as far as possible) equal numbers of observations.

Statistical significance: this is the likelihood that a finding or a result is caused by something other than just chance.

Stroke: occurs when the blood supply to the brain is disturbed. Like all organs, our brain needs the oxygen and nutrients provided by our blood to function properly. If the supply of blood is restricted or stopped, brain cells begin to die. This can lead to brain damage and possibly death. (NHS Choices).

Three-year moving average means of annual mortality rates: are calculations of the mean of annual rates covering overlapping three-year periods. These are used to make trends over time more easy to interpret.

Wider determinants of health: are the general socio-economic, cultural and environmental conditions that impact on health. These wider determinants largely determine the health status of individuals but generally are beyond the reach and influence of conventional health services.
The Health Poverty Index is an information tool that allows the comparison of different populations in England in terms of health poverty. The health poverty of a population is defined as a combination of both its present state of health and its future health potential or lack of it. For more information see http://www.hpi.org.uk

Indicators:

GVA: measures the contribution to the economy of each individual producer, industry or sector in the UK (ONS, 2002), and has recently replaced Gross Domestic Product (GDP) as the preferred indicator of regional economic prosperity (House of Commons, 2003). This indicator reflects regional economic strength.

Change in job supply: percentage increases in full-time equivalent employee jobs between 1991-2001 by place of work.

Educational resourcing: average expenditure per pupil.

Social capital: levels of social capital:
- measure of the size of out-migration from an area
- modelled estimate of the proportion of people who trust their neighbours.

Educational quality: the quality of education provided to children at primary and secondary schools, in terms of numbers of pupils per teacher and the value added to pupils (Key Stage results).

Income: proportions of the population experiencing income deprivation in the area.

Wealth: measures of high-value property areas:
- proportion of dwellings falling in Council Tax Bands F and above
- average house prices by property type weighted by number of sales in each property type.

Human capital: average examination results at three stages: Key Stages 2, 3 and 4.

Local government resourcing: local government expenditure per capita to produce healthy local and home environments (excluding any social security spend).

Expenditure on:
- personal social services
- sports and recreation
- environmental services.

Preventative care resourcing: health service expenditure per capita on services promoting healthy areas.

Recreation facilities: access to recreational facilities per capita.

Effective preventative healthcare: measures of effectiveness in preventative healthcare:
- flu vaccine uptake
- effective vaccination services
- breast screening uptake
- cervical screening uptake
- family planning
- low birth weight.

Lifestyle: measuring of healthy lifestyles:
- smoking
- 5 a day
- hospital admission rate for alcohol-related conditions
- hospital admission rate for drug-related conditions
- physical activity.

Home environments: the quality of home environments:
- proportion of households containing only one person
- modelled estimate of severe lack of social support
- air quality
- proportion of social and private housing in poor condition.

Work and local environment: low-control at work and living environments:
- low-control in work environments
- unemployment
- violent crime
- burglary
- theft
- criminal damage.

Health care resourcing: net health care expenditure (in-patient and out-patient) per capita for medical, surgical and psychiatric specialties.

Social care resourcing:
- personal social services
- expenditure per capita.

Effective primary care:
- GP per capita
- avoidable mortality under age 75 years
- emergency admissions for chronic conditions.

Access to secondary care: ratio of number of operations by population in need:
- joint replacement
- cataract removal
- coronary artery bypass graft/angioplasty (heart surgery to repair narrowed arteries).

Access to social care:
- social service staff per capita
- residential/nursing care places for those aged over 65.

Quality of social care: effectiveness of care for vulnerable individuals in society:
- suicide
- emergency admissions of over 75s
- emergency psychiatric readmissions within 90 days of discharge.

Psychological morbidity: measures of mental ill health:
- suicide
- benefits for mental health conditions
- prescribing for anxiety/depression
- psychiatric admissions.

Health capital: an individual’s potential for health across the life course:
- modelled estimates of obesity
- modelled estimates of blood pressure
- modelled estimates of cholesterol
- low birth weight (for infants).

Physical morbidity: directly age and gender standardised illness and disability ratio.

Premature mortality: directly age and gender standardised rate of average annual years of life lost up to age 75 per 10,000 residents.