State of Suffolk: Suffolk communities: groups at risk of disadvantage

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Note:
On 1 April 2019:
West Suffolk Council replaced Forest Heath District Council and St Edmundsbury Borough Council
East Suffolk Council replaced Suffolk Coastal District Council and Waveney District Council
This State of Suffolk report was created before these changes, so gives information for the pre-2019 council areas.

1 Five key points
1. In 2016/17, it was estimated that one in five working age adults in Suffolk were living with a disability (around 80,000 people) and nearly adults of state pension age were living with a disability (around 87,000 individuals). (3.1 People with physical disabilities)

2. People with learning disabilities find it hard to understand new and difficult information, and to learn and remember new things. In 2017/18, around 3,900 GP registered patients in Suffolk had a diagnosed learning disability. (3.2 People with learning disabilities)

3. Severe mental illness describes conditions such as schizophrenia, bipolar disorder and other psychoses (conditions which involve losing touch with reality or experiencing delusions). In 2017/18, 6,593 people registered with a GP in Suffolk had a diagnosis of severe mental illness. (3.3 People with severe mental illness)
4. It is estimated that around 1,500 members of Gypsy and Traveller communities live in Suffolk, and that more than 1,000 members of Roma communities live in Ipswich. These communities are likely to experience poor health and have a life expectancy ten years lower than the general population. (3.4 Gypsy, Roma and Traveller communities)

5. The prison population is characterised by having experienced high levels of adverse childhood and social factors, alongside low levels of education achievement. There are high levels of mental ill health amongst prisoners, and substance misuse is also a health concern for this population. (3.5 Prisoners)

See also:
- Where we live
- How we develop

2 Why are groups at risk of disadvantage important in Suffolk?

"Groups at risk of disadvantage" is an umbrella term describing a community or a group who may experience health inequalities based on specific characteristics, conditions or beliefs. The following list outlines some of the issues sometimes experienced by such groups and which may contribute to a reluctance or difficulty in accessing or receiving services/treatment: [1]

- members of communities sometimes have limited knowledge of their rights to services or how to access them appropriately
- for some, language and communication pose difficulties when English is not spoken as a first language. Absent or inadequate interpreting services can compound the problem
- incomplete data collection by the health sector e.g. for ethnicity, means that the specific health needs of each community group cannot easily be assessed
- limited joint working between the health sector and community or advocacy groups means there are fewer chances to reach out to specific communities
- the perception among some communities is that providers of services have a limited awareness of important cultural issues
- some groups experience specific health issues, which can contribute to health inequalities in Suffolk

There is no singular, exhaustive list that identifies all groups at risk of disadvantage. Different geographic areas and localities will have different groups that may be at risk of health inequalities based on demographic, economic and social factors and influences. This report attempts to identify some of those communities and groups within Suffolk, and the specific issues they may experience in respect of accessing and receiving services. The groups in Suffolk that will be considered in this section are:

- people with physical disabilities
- people with learning disabilities
- people with severe mental illness (SMI)
- Gypsy, Roma and Traveller communities
• prisoners

People who are homeless are discussed in State of Suffolk "Where we live" (the housing section of the 2019 State of Suffolk, and people who have been exposed to adverse childhood experiences are discussed in the development section ("How we develop").

This is not an exhaustive list nor is it unique to Suffolk. There are other groups and communities within the County who also experience health inequalities based on the beliefs that they hold, conditions they live with or characteristics. Suffolk Public Health's Groups at risk of disadvantage needs assessment identified and discussed in detail the following additional communities and groups:[2]

• Asylum seekers and refugees
  With a Home Office designated dispersal centre for asylum seekers and refugees in Ipswich, there are usually between 70-90 people in the County either applying for a decision, appealing a decision or being designated a refugee for five years prior to applying for indefinite leave to remain. Asylum seekers and refugees have distinct needs and require appropriate services. While many asylum seekers arrive in good health, others may be in poor emotional and physical health.

  Many asylum seekers find the NHS system difficult to understand; the GP’s role as gatekeeper to other services is not usual in other countries. Even though the system is explained to asylum seekers, they may still worry that they will be charged for services. Their access to services may depend on them having a clearer understanding of their entitlements and the way the system works.

• Migrants from Eastern Europe
  Migrants from Eastern Europe generally have higher consumption of alcohol, tobacco products and illicit drugs. In particular, alcohol is a major cause of ill health in the Eastern European region. Central and Eastern European countries have a higher prevalence of obesity than those in Western Europe, especially among women. Eastern European populations have had a particularly high mortality rate from cardiovascular disease.

  Many economic migrants lack access to good housing advice, often due to language barriers, uncertainties about entitlement and service opening hours. They often occupy poorer quality private rented housing. Migrants may also lack knowledge of the UK health system and specifically of the role of the GP as the gatekeeper to the system. Additionally, speaking limited English, living in rural locations and not being registered with a GP may all make it harder for migrants to use the NHS.

• Females at risk of female genital mutilation
  Female genital mutilation (FGM) refers to all procedures involving partial or total removal of the external female genitalia or other injury to the female genitalia for non-medical reasons. It has no medical benefits and serious potential harms including both short-term and long-term physical and psychological problems. It is usually carried out on girls aged between 0 and 15 and is linked to cultural beliefs. It is illegal to carry out FGM in the UK.
• **People taking new psychoactive substances**

New psychoactive substances (NPSs) are psychoactive substances designed to mimic the effects of ‘traditional’ illicit drugs. Minor changes in chemical composition are introduced to these substances so that they fall outside the scope of the Misuse of Drugs Act 1971. Although there has been a downward trend in the use of illicit drugs over the last decade, NPS use appears to be increasing.

Users of NPSs tend to be people who also use other illicit drugs. Different groups of NPS users have been identified including: participants in the night-time economy; men who have sex with men (MSM); some groups of young adults; vulnerable young people living in more disadvantaged areas. There is limited evidence on the effects of NPSs; health effects can be unpredictable and idiosyncratic because they often contain a mixture of substances, or unknown substances.

• **People in rural communities**

Some of the challenges facing rural populations include lack of access to services, high travel costs, and limited public transport options. Many services in rural areas such as postal services, doctors’ surgeries, public houses, libraries, village shops and dentists are reducing. Services in rural areas will be increasingly difficult to provide because the population is ageing, and younger people are moving into urban areas for cheaper accommodation nearer to their place of work. This reduces the availability of the extended family to provide help when it is needed.

• **Transgender community**

‘Transgender’ or ‘trans’ is used as an inclusive term to describe people whose experience of gender differs from their biological sex assigned at birth, regardless of whether or not they have received medical intervention. There is more information on the Suffolk Gender Identity Hub ([I’m here as a professional or manager](#)) about language.

Gender dysphoria is the discomfort or distress arising when a person’s gender identity – their psychological sense of themselves as male or female – does not match the sex to which they were assigned at birth. This mental distress is exacerbated by the impact of other people’s reactions, the stress associated with managing the condition and the disruption of personal relationships to which it often gives rise.

Trans people have a high incidence of anxiety and depression. They are more likely to self-harm, and attempted and completed suicide is more common. Consumption of tobacco, alcohol and illicit drugs is higher among trans-people than the general population.[2],[7]

• **Sickle cell community**

Sickle cell disease is the commonest genetic disorder in the UK. People affected cannot make enough normal haemoglobin (the protein that carries oxygen in red blood cells). Instead, an abnormal haemoglobin is produced, which changes its structure when oxygen levels are low.
Sickle cell disease is a serious and potentially life-threatening health problem. There are only limited means of preventing sickle cell disease. However, mothers are tested routinely during antenatal care for their sickle status and infants are also screened for the condition. There is no widely available cure for sickle cell disease. However, there are several treatments which relieve symptoms and prevent or treat complications. There are fifteen people with sickle cell disease known to the NHS in Suffolk.

3 What is the local picture?

3.1 People with physical disabilities

Physical disability is when a person’s physical functioning, mobility, dexterity, or stamina is limited. A physical impairment can also be considered a physical disability when it limits aspects of day to day life, for example, respiratory disorders, blindness and sleep disorders.

Physical disabilities can be genetic and experienced from birth, they may develop through old age or can result from a specific event such as a stroke or accident. Acquired disabilities include arthritis, asthma, blindness, deafness, diabetes and kidney disease. Living with a physical disability impacts on day to day living and the ability to carry out daily activities such as getting dressed or cooking a meal. People with physical disabilities can be at greater risk of ill health, both physical and mental, and can be slower to recover from illness. Physically disabled people are also often disadvantaged in accessing employment, leisure and social opportunities.

The 2011 Census contained a question about self-reported health. However, this information source lacks detail about specific health conditions, and is nearly eight years old. In order to estimate the number of people in Suffolk with a disability, population prevalence estimates from the UK Family Resources Survey have been applied to the 2016 mid-year population estimates for Suffolk. In 2016/17, it was estimated that one in five (19%) working age adults and close to half (45%) of adults of pensionable age in Suffolk were living with a disability, which equates to around 167,000 adults (Table 1).

Using the same methodology, it appears that large numbers of people across all age groups in Suffolk are living with a condition that affects their mobility (Table 1). The impact of this may range from finding it difficult to do some basic day to day activities to requiring full time care to help with daily living. Other associated issues include loneliness, particularly if the impairment or disability means the person is unable to leave their own home.

Table 1. Estimated number of people in Suffolk with a physical disability or specific impairment type by life stage, Suffolk, 2016/17

<table>
<thead>
<tr>
<th>Estimation</th>
<th>Children (under 16 years)</th>
<th>Working-age adults</th>
<th>State Pension age*</th>
<th>Total (all ages)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>%</td>
<td>Number</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Estimated number of Suffolk residents</td>
<td>134,820</td>
<td>100.0%</td>
<td>422,945</td>
<td>100.0%</td>
</tr>
<tr>
<td>Estimated number of Suffolk residents with a disability</td>
<td>10,715</td>
<td>8.0%</td>
<td>80,305</td>
<td>19.0%</td>
</tr>
<tr>
<td>Mobility</td>
<td>29,660</td>
<td>22.0%</td>
<td>161,740</td>
<td>43.0%</td>
</tr>
<tr>
<td>Hearing/breathing/fatigue</td>
<td>39,855</td>
<td>34.0%</td>
<td>149,925</td>
<td>35.0%</td>
</tr>
<tr>
<td>Disability</td>
<td>14,852</td>
<td>11.0%</td>
<td>105,860</td>
<td>28.0%</td>
</tr>
<tr>
<td>Vision</td>
<td>9,335</td>
<td>7.0%</td>
<td>58,015</td>
<td>9.0%</td>
</tr>
<tr>
<td>Estimated number of Suffolk residents with a specific impairment type</td>
<td></td>
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</tr>
</tbody>
</table>
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* Note: State pension age adults are defined here as males aged 65 and over and females aged 60 and over.

Figures rounded to 5.


The predicted number of adults aged under 65 with a moderate or severe physical disability (both now and in the future) are published on the Projecting Adult Needs and Service Information (PANSI) website. Among those aged under 65, the number of people with a moderate or severe physical disability in Suffolk is expected to fall slightly between 2018 and 2035 (Figure 1).

Figure 1: Number of people with a moderate or severe physical disability by age group, Suffolk, 2018 and 2035

The predicted number of adults aged under 65 with a moderate or severe physical disability (both now and in the future) are published on the Projecting Adult Needs and Service Information (PANSI) website. Among those aged under 65, the number of people with a moderate or severe physical disability in Suffolk is expected to fall slightly between 2018 and 2035 (Figure 1).

3.2 People with learning disabilities

There are different definitions of what a learning disability is. The definition used in Suffolk County Council’s Mental Health Needs Assessment defines people with learning disabilities as:

“finding it hard to understand new and difficult information or finding it difficult to learn and remember new things. Some people have difficulties coping on their own and finding answers to everyday problems. These difficulties start when a person is a child and will affect them their whole life”.

In 2017/18, 3,911 patients registered with GPs in Suffolk had a diagnosed learning disability (Figure 3). This equates to a prevalence of 0.5% among the GP registered population, which
is similar to the national prevalence of 0.49%. The prevalence of learning disabilities in Ipswich and East Suffolk CCG and West Suffolk CCG were both 0.48%. The highest prevalence is focused in Great Yarmouth and Waveney CCG (0.60%) and Waveney district (0.59%); both are significantly higher than England (0.49%) (Figure 2).

Figure 2: Prevalence of learning disabilities in Suffolk\(^8\)

![Prevalence of learning disabilities in Suffolk](image)


People with learning disabilities face health and social inequalities. Some of these can be attributed to genetic factors and to poorer access to health services.\(^7\) A Public Health England survey suggests that some behavioural risk factors were more common in people with learning disabilities, such as a poor diet, low levels of physical activity, smoking, alcohol use, and hospital admissions for newly diagnosed conditions.\(^9\) This suggests that people with learning disabilities may benefit from support to manage existing health conditions and make healthy lifestyle choices to avoid developing future health problems.

There is higher prevalence of mental ill health in adults with learning disabilities than the general population. Two in five (40.9%) people with a learning disability are likely to have mental ill health compared to nearer one in four for the general population. People with a learning disability are also five times more likely to develop dementia, and to develop dementia at a younger age. Social factors such as bullying, harassment and stigma are often experienced by people with learning disabilities and are associated with mental ill health. People with learning disabilities have higher rates of morbidity than the total population: a population-based study found 99.2% of participants with learning disabilities had at least one physical health condition.\(^7\) Additionally, people with learning disabilities die, on average, 15-20 years earlier than the general population. The average life expectancy for people with Down's syndrome is around 59 years.\(^7\)
Unmet need for people with learning disabilities may be significant, with an estimated third of people of working age in Suffolk with a moderate to severe learning disability not receiving services that could improve their health and/or quality of life.\textsuperscript{[7]}

3.3 People with severe mental illness (SMI)
Severe mental illness (SMI) describes conditions such as schizophrenia, bipolar disorder and other psychoses (conditions which involve losing touch with reality or experiencing delusions). In 2017/18, 6,593 people registered with a GP in Suffolk had a diagnosis of severe mental illness.\textsuperscript{[8]} This equates to a prevalence of 0.89% among the GP registered population, which is significantly lower than the national prevalence of SMI of 0.94%. Both Ipswich and East Suffolk CCG and West Suffolk CCG had a SMI prevalence that was significantly below the national average. However, 1.13% of GP registered patients in Great Yarmouth and Waveney CCG had SMI, which is significantly higher than the England average (0.94%). The prevalence of severe mental illness in the district of Waveney was 1.12% of all GP registered patients.

\textit{Figure 3: Prevalence of severe mental illness in Suffolk, CCGs and Waveney district, 2017/18}\textsuperscript{[8]}


Research shows that patients who live in more deprived areas have a higher prevalence of SMI, and patients with SMI living in more deprived areas have a higher prevalence of physical health conditions.\textsuperscript{[10]} Socio-economic deprivation is recognised as both a cause and consequence of SMI, with sufferers experiencing an increased risk of “social withdrawal” such as unemployment.\textsuperscript{[11]}

People with SMI experience poor outcomes in terms of physical health and mortality rates. They have increased likelihood of unhealthy lifestyles including alcohol or substance misuse and smoking. Other health impacts of severe mental illness include:\textsuperscript{[11]}
• life expectancy appears to be reduced by 15-20 years compared to the general population
• 60% of this excess mortality is estimated to be due to physical illness (not suicide), and is mostly from cardiovascular disease
• increased prevalence of asthma, diabetes, chronic obstructive pulmonary disease (COPD), coronary heart disease (CHD), stroke and heart failure
• people with SMI have double the risk of obesity and diabetes and of heart attack or stroke
• evidence tends to suggest that SMI does not increase the prevalence of cancer, nor make it more likely that cancer is diagnosed at an advanced stage. However, people with a history of SMI had significantly worse cancer survival rates

People experiencing SMI appear to be less able to self-manage long term conditions, e.g. by following treatments and attending appointments.[11] People with SMI may not feel able to access preventive and general health care as readily as others. GPs offer an annual health check for those with SMI, and NHS health checks are available for adults aged 40 – 74. However, patients with SMI are less likely to receive full health assessments than the England average.[11]

Health care professionals working in mental health services may not have the knowledge and skills, awareness of pathways and provision, or even the equipment, to support general health care. People with long-term SMI have specific needs and are likely to require specialist support from staff experienced in mental ill health when it comes to identifying, monitoring and addressing behavioural risk factors.[11]

3.4 Gypsy, Roma and Traveller communities

Gypsies and Travellers are designated ethnic minorities, numbering 604 (0.1%) of Suffolk residents in the 2011 Census, although this is likely to be an underestimate.[2] A more realistic estimated Gypsy and Traveller population in Suffolk is around 1,500 individuals.[2] While there are no transit sites in Suffolk, there are three permanent sites in West Meadows, Kessingland and Mildenhall. An estimate from the Roma community suggests there are about 1,000 Romanian Roma and 100 Bulgarian Roma living in Ipswich, many of whom arrived in the UK from Central and Eastern Europe since 2004.[2]

These communities are likely to experience poor health and have a life expectancy ten years lower than the general population. Many are not registered with a GP. Particular health issues faced by these groups include long-term illness, respiratory diseases such as asthma and bronchitis, chest pain, chronic cough, higher maternal and neonatal death rates, high smoking rates, and anxiety and depression.[2]

A report commissioned by the National Inclusion Health Board and carried out by The Traveller Movement noted that "the conditions in which members of this [Gypsy and Traveller] group are born, grow, live, work and age contribute significantly to their poor physical and mental health outcomes prospects".[12] The report identified high levels of mental health illnesses, such as anxiety and depression, potentially triggered and reinforced by feelings of insecurity of their accommodation, the threat of eviction, and/or poor site conditions. Emotional wellbeing was also affected by poor relationships with neighbours, and
experiences of racism and harassment. Physical health was affected by busy roads and noise pollution, as well as the condition of living accommodation.

A report published by the Equality and Human Rights Commission looking at inequalities faced by Gypsy and Traveller communities included the following findings:[13]

- Gypsies and Travellers die earlier than the rest of the population
- they experience worse health, yet are less likely to receive effective, continuous healthcare
- there is an unquantified but substantial negative psychological impact on children who experience repeated brutal evictions, family tensions associated with insecure lifestyles, and an unending stream of overt and extreme hostility from the wider population
- employment rates are low, and poverty high
- there is an increasing problem of substance abuse among unemployed and disaffected young people
- there are high suicide rates among the communities
- there is a lack of access to culturally appropriate support services for people in the most vulnerable situations, such as women experiencing domestic violence
- Gypsies' and Travellers' culture and identity receive little or no recognition, with consequent and considerable damage to their self-esteem

Some of the health impacts, outcomes and inequalities identified for Gypsies and Travellers also apply to Roma communities. A report into Roma Health commissioned by the European Commission found that the poor health of Roma is closely linked to social determinants of health.[14] It identifies language and literacy as barriers to access to healthcare, as well as cultural norms preventing them from accessing services for support with mental health, sexual health and drug and alcohol misuse.

Specific studies relating to UK Roma found an increasing prevalence of illicit drug use amongst Roma men, and reported diets containing a particularly high fat content, alongside a low awareness of healthy eating.[15],[16] The same study also reported high prevalence of diabetes, cardiovascular disease, premature myocardial infarction, obesity and asthma amongst Central and Eastern European Roma.

Strongly held cultural health beliefs by Gypsy, Roma and Traveller communities can have a significant impact on attitudes towards health prevention and care, and limit uptake of services, with health screening and vaccinations, for example, viewed with suspicion. In addition, living in poor quality housing can exacerbate some conditions and overall poor health, further adding to the vulnerability of these groups to illness and disease.

As with other groups at risk of disadvantage, Gypsy, Roma and Traveller communities can face difficulties accessing services. This may be because cultural beliefs lead to a mistrust of services. Additionally, a lack of familiarity with health services and potential language barriers may make it difficult for these groups to access health services.

3.5 Prisoners
At the end of 2018, there were 82,384 prisoners in the UK, of whom 95.4% were male.[26]
Suffolk has three prisons: HMP Highpoint, HMP and YOI (Young Offender Institution) Hollesley Bay and HMP Warren Hill. However, most Suffolk prisoners are sent to Norwich prison in Norfolk. As of January 2019, more than 250 Suffolk prisoners were situated in Suffolk/Norfolk prisons (Table 2).

Table 2: Suffolk prisoners in Suffolk/Norfolk prisons, January 2019

<table>
<thead>
<tr>
<th>Prison</th>
<th>Capacity</th>
<th>Number of Suffolk prisoners</th>
<th>Suffolk prisoners as % of total prisoners</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bure</td>
<td>624</td>
<td>Small number</td>
<td>N/A</td>
</tr>
<tr>
<td>Hollesley Bay</td>
<td>485</td>
<td>11</td>
<td>2%</td>
</tr>
<tr>
<td>High Point</td>
<td>1,289</td>
<td>35</td>
<td>3%</td>
</tr>
<tr>
<td>Norwich</td>
<td>769 [441]*</td>
<td>167]*</td>
<td>39% [of 441]*</td>
</tr>
<tr>
<td>Wayland</td>
<td>1,017</td>
<td>44</td>
<td>4%</td>
</tr>
<tr>
<td>Warren Hill</td>
<td>258</td>
<td>Small number</td>
<td>N/A</td>
</tr>
</tbody>
</table>


Note: HMP Norwich is located over two sites. The capacity of 769 relates to the capacity over both sites, but data on the number of prisoners could only be provided for one site (shown in square brackets).

The prison population is characterised by having experienced high levels of adverse childhood and social factors, alongside low levels of education achievement. There are high levels of mental ill health amongst prisoners, and substance misuse (and associated health impacts such as hepatitis B and C) is also a health concern for this population. In addition, the social circumstances of individuals prior to incarceration mean that chronic conditions (such as asthma, diabetes, cancer, coronary heart disease, and epilepsy) may have not been diagnosed or may have been poorly managed.\(^{[28]}\)

People in contact with the criminal justice system face significant health inequalities, as identified in a news release by Public Health England:\(^{[29]}\)

- the mortality rate for prisoners is 50.1% higher than the rest of the population
- people in and out of the criminal justice system are four times more likely to be smokers
- 15% of prisoners had been homeless immediately prior to custody, compared to a lifetime experience of homelessness of 3.5% in the wider population
- 42% of men and women in prison and 17.3% on probation suffered from depression, compared to just over 10% of the rest of the population
- many prisoners have the biological characteristics of those who are 10 years older than them

The National Partnership Agreement for Prison Healthcare in England 2018-2021 is a committed collaboration between the Ministry of Justice, Her Majesty’s Prison and Probation Service, Public Health England, the Department of Health & Social Care, and NHS England.\(^{[30]}\) There are three core, shared objectives:
1. To improve the health and wellbeing of people in prison and reduce health inequalities
2. To reduce re-offending and support rehabilitation by addressing health-related drivers of offending behaviour, and
3. To support access to and continuity of care through the prison estate, pre-custody and post-custody into the community

The 2016/17 Health Justice Annual Review\[^{31}\] describes the ‘Whole Prison Approach’ to health and wellbeing, which emphasises how prisons are an integral part of local healthcare services in the community and should enable people to successfully transition back into the community from prison.\[^{31}\] It addresses wider determinants of health, such as education and life skills, as well as health promotion, health education, patient education and prevention.

4 What policies affect groups at risk of disadvantage?
In recognition that some groups face disadvantages and inequalities, in April 2011 the Public Sector Equality Duty came into effect in England, Scotland and Wales. The Public Sector Equality Duty extends the protection previously given by duties covering race, disability and sex to a wider group of ‘protected characteristics’, including: age; disability; sex; gender reassignment; pregnancy and maternity; race; religion or belief; marriage and civil partnership; and sexual orientation.\[^{38}\] In addition to these nine nationally protected characteristics, Suffolk County Council also takes in account rurality when considering the impact of any new policies and strategies or amendments to those already in place.

The Public Sector Equality Duty requires that all public organisations in Great Britain consider all individuals - whether working for it, affected by a policy or strategy developed and implemented by it, or using a service delivered by it - when undertaking its day to day business. Public sector organisations are also required to show ‘due regard’ to the need to eliminate discrimination, advance equality of opportunity, and foster good relations between different people when carrying out activities.

Suffolk County Council, as a public sector organisation, is bound by the requirements set out in the Equality Act 2010. In order to meet its statutory duty under the Equality Act 2010, Suffolk County Council has an Equality Impact Assessment Policy that ensures it considers the impact on individuals whenever a new policy or strategy is introduced, or if there is an amendment to a current policy or strategy that is already in effect. It is an effective way to identify and mitigate any impact (positive or negative) that a change could have on different people according to their protected characteristics.

5 Further information
More information about some of the groups identified in this paper can be found at the sources listed below.

Public Health England produce a number of data profiles on various health and wellbeing topics. These include profiles on:

- Severe Mental Illness: fingertips.phe.org.uk/profile-group/mental-health/profile/severe-mental-illness
- Learning Disabilities: fingertips.phe.org.uk/profile/learning-disabilities

A report into Health and Wellbeing in Rural Areas by the Local Government Association and Public Health England can be found here: [www.local.gov.uk/sites/default/files/documents/1.39_Health%20in%20rural%20areas_WEB.pdf](http://www.local.gov.uk/sites/default/files/documents/1.39_Health%20in%20rural%20areas_WEB.pdf)

A House of Commons Library Briefing Paper on Gypsies and Travellers can be found here: [researchbriefings.files.parliament.uk/documents/CBP-8083/CBP-8083.pdf](http://researchbriefings.files.parliament.uk/documents/CBP-8083/CBP-8083.pdf)

The following Needs Assessments are on the Healthy Suffolk website:


6 References


Suffolk County Council, 2018, p. 27. Available: /jsna/health-needs-assessments/mhna-2018


