The purpose of this first Joint Strategic Needs Assessment (JSNA) for Suffolk is to, for the first time, give decision makers in Suffolk a comprehensive view of the needs and wants of the people of the county. It will enable us to focus our efforts on those communities and groups in Suffolk whose needs are not being met. The JSNA will also identify the demographic, health and social trends which are likely to have implications for the way we deliver services in the future, allowing us to plan to meet these emerging challenges in an effective and affordable way.

The Joint Strategic Needs Assessment has been produced in partnership by Suffolk County Council, Suffolk Primary Care Trust and Great Yarmouth and Waveney Primary Care Trust, and led by the Director of Adult and Community Services at the Council. It is a good example of agencies working increasingly together to deliver a better way for the people of Suffolk.

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Adults & Healthier Communities Board
(Local Area Agreement Block 3)
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Executive Summary

This document sets out the findings from the Joint Strategic Needs Assessment (JSNA) for Suffolk developed by representatives from Suffolk County Council, Suffolk Primary Care Trust and Great Yarmouth and Waveney Primary Care Trust (PCT) from May 2007 to November 2007.

This JSNA has been guided by the draft Commissioning Framework for Health and Wellbeing (published March 2007) which proposes to establish a duty on primary care trusts and upper tier local authorities to produce a Joint Strategic Needs Assessment (JSNA) – the framework gives practical advice on the minimum data sets required.

The Joint Strategic Needs Assessment for Suffolk has been produced in anticipation of this requirement, and contains not only the datasets set out in the draft Commissioning Framework (See Appendix 1), but also draws on other data sources available in Suffolk.

The JSNA presents findings and key issues for planners, commissioners and service providers under each of the following headings:

- Population – includes baseline figures and projections for different age groups and different districts (pages 14 - 23).
- Health Needs – includes main causes of death for Suffolk residents, and estimates of the prevalence of some diseases, including mental ill health, within the population (pages 24 - 34).
- Health and Social Care – include baseline information on adult and community services, the role of family carers, emergency hospital admission and other hospital and community health services (pages 35 – 51).
- Health Inequalities and Well Being – provides information on a range of health and well being indicators, includes life expectancy, unemployment, debt, fuel poverty, educational attainment, and other economic and social factors. It also includes health behaviours, uptake of prevention services, and the needs of some vulnerable groups, all documenting inequalities across the county (pages 52 – 86).
- Children and Young People – provides information based on the “Every Child Matters” agenda including demographics, black and ethnic minority statistics, school attainment tests, levels of obesity in young people and number of children recorded on the child protection register (pages 87 – 95).
- Environment, Transport and Access to Services – Geographical distribution of Suffolk population, rural isolation issues and global warming trends (pages 96 -100).
- Key, Cross Cutting Issues – Rural and urban issues and implications for commissioners and service providers (pages 110 – 113).
Some of the key challenges identified in this JSNA for Suffolk commissioners and providers both now and for the future are:

- The growth in the elderly population which increases with successive age bands, with a projected 49% growth in the over 65s and a 90% growth in the over 85s by 2021. This implies a significant rise in demand for all age related services and support.
- Meeting the diverse needs of new arrivals to the County, as well as those of already established black and minority ethnic groups.
- Working collaboratively to address the main causes of death in Suffolk which are circulatory disease, cancer and respiratory disease.
- Planning to meet the multi-agency needs of people with dementia in Suffolk which by 2028 is projected to rise by 62%.
- Supporting the number of unpaid carers in Suffolk now estimated to be 66,133 and projected to rise with the growth in the older population.
- Developing pro-active multi-agency case management programmes across health and social care to manage emergency hospital admissions.
- Addressing the difference of 12.3 years in life expectancy between the wards in Suffolk with the highest and the lowest life expectancy.
- Planning health and social care services to meet the demands made by the additional 58,600 homes to be built in Suffolk by 2021.
- Planning a multi-agency response to tackling district variations in levels of unemployment and debt rates and the prevalence of fuel poverty in Suffolk.
- Providing health and well being services for children and young people under 18 who represent around 24% of the Suffolk population. In particular, working on transition arrangements between children and adult services and addressing the needs of vulnerable young people such as young carers.
- Targeting the 18% of 11-year olds in Suffolk who were recorded as obese in June 2006 with sensitive and appropriate service interventions.
- As 40% of the population of Suffolk live outside the main urban areas, services must be developed to meet the needs of these scattered, rural communities.
- Developing services and schemes to protect the elderly and other vulnerable groups from extremes in weather, particularly as climate change impacts on Suffolk.
- Responding to perceptions of public sector services as they are provided and involving the public in service planning, commissioning and review.
- Targeting the marked health, social and economic inequalities that exist between different communities in Suffolk.

The JSNA provides a shared evidence base of health and well being needs for Suffolk. Together with national priorities and targets, this evidence base will shape priority target areas for the Suffolk ‘Health and Well Being Plan’ and the subsequent Suffolk Local Area Agreement (LAA) targets for the period 2008-2012. It will also provide a framework to support the future planning and commissioning of services.

The JSNA will be refreshed for the next 3-year planning period (2012-2015). District and borough councils, the voluntary and independent sectors, and the public will all be actively engaged in its development.
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## Appendices
Section 1: Introduction

When the White Paper “Our Health Our Care Our Say” was published in 2006\(^1\) it launched a new direction for the way health and social care services would be delivered. The White Paper identified the need for a regular strategic needs assessment to be conducted that would enable local services to plan ahead, and to support the development of the wider health and social care market.

The recently published draft Commissioning Framework for Health and Wellbeing (March 2007)\(^2\) builds on the White Paper. It proposes to establish a duty on primary care trusts and upper tier local authorities to produce a Joint Strategic Needs Assessment (JSNA) and gives practical advice on the minimum data sets required. The Joint Strategic Needs Assessment for Suffolk has been produced in anticipation of this requirement, and contains not only the datasets set out in the in the draft Commissioning Framework. (See Appendix 1), but also draws on other data sources available in Suffolk. This is a first attempt at bringing together a wide range of information on the health and wellbeing status of the population in Suffolk, including health inequalities, and identifies the main current, emerging, and future issues for the many different groups and communities in the County.

The Department of Health sees the JSNA as a critical tool to inform the commissioning intentions of primary care trusts and social care services as well as to inform development of the Sustainable Community Strategies and Local Area Agreements\(^3\). The JSNA will also inform Suffolk’s Adults Health and Wellbeing Strategy. In the case of children and young people and developing services for them and their families, the JSNA should be seen as a complement to the statutory Children and Young People’s Plan 2006-09 produced through the Children’s Partnership Trust.\(^4\)

The Joint Strategic Needs Assessment for Suffolk has been produced between May and November 2007. It is the result of close partnership between the Joint Director of Public Health, the Director of Public Health for Great Yarmouth and Waveney, the Directors of Adult and Community Services and Children and Young People’s Services in Suffolk County Council, and the Chief Executives and Commissioning Directors of Suffolk Primary Care Trust and Great Yarmouth and Waveney Primary Care Trust. This document will act as a shared base of evidence to inform decision-making and commissioning by all of the above agencies. It has also been a catalyst for developing closer working relationships, establishing a strong understanding of shared goals and aspirations, and providing a good foundation for further joint working and collaboration into the future.

Finally, it is important to note that although the statutory partners in this first JSNA for Suffolk have been the two Primary Care Trusts in Suffolk and the County Council, other organisations such as the Suffolk Public Health Observatory, Suffolk Supporting People and Suffolk Sport have contributed to the content of this document. It is hoped that in the future, successive JSNAs will more actively engage with district and borough councils, the voluntary and independent sectors, and the public.

Figure 1.1 shows how the JSNA can influence planning and commissioning decisions to improve health and wellbeing.

---

\(^1\)“Our health, our care, our say; a new direction for community services”, Department of Health, 2006
\(^3\)Commissioning Framework for Health and Well Being, 2007
\(^4\)The Children and Young People’s Plan is underpinned by a joint needs assessment which was carried out with partners in 2005/06 and reviewed in 2007 as part of the annual review of the Plan.
What do we mean by health and wellbeing?

When talking about what factors determine the health and wellbeing status of individuals and communities in Suffolk, what do we mean? The World Health Organisation defines health as “a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity.” This is a definition that is relevant to this Joint Strategic Needs Assessment, as it applies equally to the work of both the primary care trusts and Suffolk County Council. Wellbeing in the JSNA will follow the same definition as that used by the Department of the Environment, Food and Rural Affairs:

“positive physical, social and mental state; it is not just the absence of pain, discomfort and incapacity. It requires that basic needs are met, that individuals have a sense of purpose, and that they feel able to achieve important personal goals and participate in society. It is enhanced by conditions that include supportive personal relationships, strong and inclusive communities, good health, financial and personal security, rewarding employment, and a healthy and attractive environment.’

In order to help us better understand and analyse the risks to the health and well being of individuals, it is useful to have a model that clearly describes what the key areas for focus and attention should be. One such model is Dahlgren and Whitehead’s (1991) “Determinants of Health” (See Figure 1.2). This model shows that a person’s health and wellbeing is influenced by many interacting factors, such as economic circumstances, people’s lifestyles (e.g. diet, smoking and exercise), and the environment in which they live.

[Note: This definition has also been proposed for the Adults Health and Wellbeing Strategy, 2008-28 and at the time this draft was sent out was pending approval from relevant management teams.]
This model has influenced the choice of issues selected for inclusion in this document, and helps in the understanding of those factors that influence health and well being.

**How to use this document**

The section headings used within this Joint Strategic Needs Assessment have been designed to be as generic as possible for ease of reference. Commissioners can review each chapter to articulate the important issues that are specific to programme group areas, e.g. commissioning for older people, mental health, learning disabilities, etc.

The report is divided into ten sections:

1. Introduction
2. Population
3. Health Needs
4. Health and Social Care
5. Health Inequalities and Well Being
6. Children and Young People
7. Environment, Transport and Access to Services
8. Voice
9. Analysis of Key Crosscutting Issues
10. Shared Priorities and Future Planning - Next steps

Sections 2 to 9 begin with a box listing ‘Interesting Facts’ that gives a flavour of some of the issues covered in each section.

Below ‘Interesting Facts’ is a box which sets out key issues that have been drawn from the section and can be used to inform planning and commissioning intentions.

Each section then gives detailed information on the current, emerging and forecasted issues in Suffolk. Section 9 “Analysis of Key Cross-Cutting Issues“, draws together the key issues identified in the previous sections, and looks at them under the following headings:
Section 10 looks at the next steps for commissioners and planners and future work required in Suffolk.

Data Issues

When using this document, readers should be mindful of some important data and analysis issues:

- Every effort has been made to ensure that all the numbers, tables, and figures contained within are accurate, however, in the case of some figures, such as information on population projections; they are unlikely to be completely accurate. Users of the document should note that instead they often give an indicative idea as to what the general situation is likely to be 5, 10 and in some cases 15 years in the future.

- There are some gaps in the data that exists, or that was accessible at the time this report was compiled. Some of these gaps are covered in Appendix 2 - ‘Work Requiring Further Research/Analysis.’ and this is one of the key issues that need to be addressed by partner agencies in the future.

- This document draws information and data from a number of sources and has had input from people from a range of organisations and services. However, this does not mean that the JSNA will have the answer to all questions. In some cases significant amounts of further research will be needed in order to provide more accurate and comprehensive information. It follows that the Joint Strategic Needs Assessment is not a replacement for, but rather a complement to, any specific service-related needs assessments such as those for housing.

- Finally, the reader should be mindful that the Joint Strategic Needs Assessment is intended to highlight the key current and emerging demographic, social and health needs that are likely to impact the various communities and groups in the County over the next fifteen years. It is a source of information from which commissioners, decision makers and providers of services across organisations can plan to deal with these issues in a joined up and coordinated way.
Section 2: Population

Interesting Facts . . .

- The most recent population estimate indicates Suffolk has 702,000 residents.
- It is forecasted that Ipswich’s population will grow by over 18% and Waveney’s will decline slightly (0.1%) between 2001 and 2021.
- The number of people aged 85 or older is predicted to rise by 14,200 in Suffolk between 2001 and 2021; and the largest increases are likely to be in Suffolk Coastal and Babergh.
- Since May 2004, 14,000 new National Insurance numbers have been given to foreign nationals in Suffolk.
- Three quarters of foreign nationals arriving in Suffolk since 2004 were aged 18-34, nearly two thirds were men and only 80 claimed any type of benefit.

Key Issues:

- The overall population of Suffolk will increase by 9.5% over the twenty-year period between 2001 and 2021, with over 18% growth in Forest Heath and Ipswich and a small reduction (0.1%) in Waveney.
- Urban areas in the County have a younger age structure than rural areas. This may have implications for the many elderly people living in isolated locations away from services and support.
- According to the 2001 Census, 39% of the over-65s in Suffolk currently live in either Suffolk Coastal or Waveney.
- The growth in the elderly population increases with successive age bands, with a 49% growth in the over 65s by 2021 and a 90% growth in the over 85s. This implies a significant rise in demand for all age related services and support, including family carers (See Section Three).
- One of the key challenges will be meeting the diverse needs of new arrivals to the County, as well as those of already established black and minority ethnic groups. (See Section 8).

2.1 Population Structure

In 2001 the population of Suffolk was 668,553. The most recent estimate from the Office of National Statistics (mid 2006) is that Suffolk has a population of 702,000.

Suffolk County Council estimates that the population of the County grew by 2.9% between 2001 and 2005 to 689,600.

Figure 2.1 shows the change in population since 2001 by parish. There is increasing concentration of the population in the towns of:

---

62001 Census.
7This is higher than Suffolk County Council’s mid 2005 population estimate of 689,600. The Office of National Statistics estimate arises from considerable double-checking of data sources and methodology, but has yet to be evaluated by Suffolk County Council.
8Suffolk County Council, mid 2005 population estimates.
Almost 60% of the population growth has occurred in Suffolk’s towns and the Ipswich area. The greatest population growth has occurred in Kesgrave, which has seen an increase of nearly 2,000 (21.8%) since 2001, followed by Bury St Edmunds 1,585 (4.5%), Ipswich 1,237 (1.1%) and Carlton Colville near Lowestoft 1,040 (15.6%). Figures in brackets show percentage change of population between 2001 and 2005 based on Suffolk County Council estimates.

Figure 2.1: Overall population change in Suffolk between 2001 and 2005

---

Although the Office of National Statistics has started to prepare small area population estimates, those prepared by Suffolk County Council are used here. The Council’s estimates have proved over the last 15 years to be a more reliable estimate of total population and its distribution in the County.
Despite strong growth overall in the County however, there have also been declines in population in some parishes, particularly in the Suffolk Coastal area. The biggest declines have been in Sutton (-582), due to movements in armed forces, Aldeburgh (-106) and Southwold (-80). More research would be required in order to establish the cause of the decline, although one likely contributory factor may be the growth in second home ownership in the area combined with an ageing population; as people are living longer, there is often only one person in a house where once there were more. This means a slowing of the natural turnover of homes and the ability for new households, such as families, to move into the area. 28% of Suffolk’s 477 parishes have experienced declines in population, 6% have dropped by more than 20 people. It should be noted however that such population decline is unlikely to be very noticeable in an individual community, although it may impact the viability of village shops, facilities and schools. For example, declining school rolls (number of pupils) is known to be occurring in the Felixstowe area. 10

2.2 Population Projections

The population of Suffolk is growing and growth is expected to continue, with a projected increase of 43,900 (6.6%) by 2016 and 63,400 (9.5%) by 2021 (based on 2001 figures), taking the population to an estimated 733,600 by 2021. 11

However, growth is not uniform across the county, and the population structure of the county is also changing. Areas such as Suffolk Coastal and Waveney have traditionally attracted older people from other parts of the country for retirement, and these areas are also seeing a growth in second homes (e.g. Southwold, Aldeburgh). This makes housing difficult for local young people to afford, and is one of the reasons for young people moving out of these areas. Added to the fact that people are living longer, this means that the favoured retirement areas of Suffolk are likely to see the proportion of older and very elderly people continue to grow, although their overall population may decline. At the same time, some areas of the county are experiencing growth in housing and in their local economy, and these areas are likely to continue to see an increase in their population.

Table 2.1 shows, for example, that the population of Ipswich and Forest Heath are both projected to experience an 18.2% growth between 2001 and 2021, whilst the population of Waveney, with its elderly population, is projected to decline slightly (0.1%). It is important to note, however, that the influence of the US Air Force on the population structure of Forest Heath is not entirely clear and is being investigated further.

---

10Suffolk Trends, Suffolk County Council, 2006.
11The East of England Regional Assembly (EERA) prepared a Regional Spatial Strategy as part of its East of England Plan. Proposed modifications to this underpin the population projections used in this document; these start at mid 2001 and assume a constant rate of housing construction until 2021. When they were prepared in December 2006, these projections used the latest demographic evidence, but this has inevitably been superseded. Furthermore, the housing proposals in the published Plan may well update the proposed modifications. In addition, reality does not always follow predictions. The outcome of the projection must therefore be regarded as the best available at the time, given the assumptions made.
This overall increase in population combined with the changing demographic, economic, social and environmental profile covered in following sections of this report will lead to a number of issues that will need to be addressed in a holistic and multi-agency manner. Suffolk’s changing age profile will lead to a population increasingly dependent on public services for much longer than was the case with previous generations.

### 2.3 Age Profile

Suffolk has an age profile that is older than for England as a whole. In 2001 the mean age of people living in Suffolk was 40.3, compared to 38.6 in England.

The overall Suffolk population distribution is shown in Figure 2.2 below. The bars represent the percentage of males (left) and females (right) in Suffolk for each five-year cohort. The two largest five-year cohorts are in the 40 - 44 and the 35 – 39 age groups, which correspond to the baby boom of the 1960s. The second largest cohort is in the 55 – 59 age group, the so-called “post war bulge.” The concern is Suffolk, as in England as a whole, is the increasing number of older people and the decreasing proportion of people of working age.
Figure 2.3 shows that the number of people aged 44 and under is projected to decrease between 2001 and 2021, with a rise in the number of people aged 45 and above.\textsuperscript{15}

The biggest changes occur in the number of people aged 55 and over. This group will increase by 81,425 people between 2001 and 2021 – an overall increase of 41%.

In contrast, and if current trends continue, the number of children aged 15 and under will reduce by over 8,000 by 2021, representing a decline of 6.6%. However, the level of decline varies across district/ borough council areas, with Waveney likely to experience the highest decline at 21%, followed by Suffolk Coastal (17.5%) and Babergh (13.1%). Ipswich and Forest Heath on the other hand are both projected to experience increases of 10.8% and 18.6% respectively.

\textsuperscript{14}Based on ONS population estimates for 2006
\textsuperscript{15}EERA, 2006.

\textit{The Joint Strategic Needs Assessment for Suffolk 2008–2011}
2.4 Population Profile of Older People

Owing to the greater longevity and a continuing influx of older migrants to the County, the number of people aged 65 and over is projected to increase by 60,800 between 2001 and 2021, an increase of 49%. This means that by 2021 a quarter of the population of Suffolk will be aged 65 or more whilst the percentage of the population of working age - from whom a pool of carers is likely to be drawn – will have reduced by 4% to 59% of the population.

Table 2.2 shows that the number of over 75s in the County is projected to increase by 11,100 between 2001 and 2011, and by a further 21,400 by 2021, equivalent to an increase of 54%\(^{16}\). The population of the over-85s will grow by 90% over the same time period. Each age band has slightly different health and care needs, which has implications for the way services are delivered.

Table 2.2: Projected Change in Suffolk of the Older Age Groups\(^{17}\)

<table>
<thead>
<tr>
<th>3.2 Age band</th>
<th>2001</th>
<th>2011</th>
<th>2021</th>
<th>% change 2001 to 2021</th>
<th>Actual change 2001 to 2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Over-65</td>
<td>123,200</td>
<td>147,500</td>
<td>184,000</td>
<td>49%</td>
<td>60,800</td>
</tr>
<tr>
<td>Over-75</td>
<td>60,300</td>
<td>61,400</td>
<td>92,800</td>
<td>54%</td>
<td>32,500</td>
</tr>
<tr>
<td>Over-85</td>
<td>15,800</td>
<td>22,900</td>
<td>30,000</td>
<td>90%</td>
<td>14,200</td>
</tr>
</tbody>
</table>

Note: Figures rounded once calculations complete.

Figure 2.4 shows that Suffolk Coastal and Waveney have the highest percentage of people aged 65 and over, 19% each. Forest Heath on the other hand has only 7% of the over 65 population.

\(^{16}\)EERA, 2006.
\(^{17}\)EERA, 2006.
Table 2.3 below expands on this. By 2021, growth in the very-elderly (over-85) population may be in excess of 100% for Mid-Suffolk, St Edmundsbury, Suffolk Coastal and Babergh, whilst Ipswich and Forest Heath will experience a rate of growth in the very-elderly population of only around 40%.

The profile and distribution of the increasingly elderly population in Suffolk will potentially have significant implications for the way services are structured and where they are provided. There are pockets with higher than average proportions of over 75s spread throughout the county, both in urban and rural areas, within approximately 10 miles of the Suffolk coast and especially in Suffolk Coastal, Mid Suffolk and Babergh.

---

*ONS Mid year 2006 estimates.*
The ethnographic profile of Suffolk is currently in a phase of rapid change. The first major wave of international migration to Suffolk after 1945 originated mainly from India, Pakistan, Bangladesh, Africa and the Caribbean, and settled mostly in the Ipswich area. Over the years and up to the present, other groups of people have arrived to Suffolk seeking asylum, for example from Iraq and Kosovo. There are also around 12,000 American military, their contractors and their families currently based in USAF Mildenhall and Lakenheath (Forest Heath District) and are included in the subsequent analysis.

The 2001 Census\textsuperscript{19} shows that 18,448 people in Suffolk described themselves as black or from a minority ethnic background (BME); this is equivalent to 2.8\% of the population, which is only a third of the level for England as a whole. Figure 2.5 shows how the different black and minority ethnic groups are distributed across the County, with the highest percentages of people from these groups located in Ipswich and Forest Heath. The Census also shows that in 2001, 4.7\% of children aged 16 and under were

\begin{table}[h]
\centering
\caption{Growth in the Over-85 Population by District\textsuperscript{19}}
\begin{tabular}{|c|c|c|c|c|c|c|}
\hline
\hline
SUFFOLK & 15,800 & 22,900 & 44.8 & 26,100 & 65.2 & 30,000 & 90.1 \\
Babergh & 1,900 & 3,300 & 75.1 & 3,900 & 105.7 & 4,500 & 136.1 \\
Forest Heath & 1,000 & 1,100 & 14.7 & 1,300 & 30.0 & 1,400 & 43.6 \\
Ipswich & 2,600 & 3,100 & 18.6 & 3,400 & 29.1 & 3,700 & 40.7 \\
Mid-Suffolk & 1,900 & 3,100 & 63.4 & 3,600 & 90.1 & 4,300 & 125.2 \\
St. Edmundsbury & 1,900 & 2,800 & 49.7 & 3,300 & 71.7 & 3,800 & 101.4 \\
Suffolk Coastal & 3,300 & 5,000 & 52.4 & 5,900 & 79.5 & 6,900 & 109.2 \\
Waveney & 3,200 & 4,300 & 35.7 & 4,700 & 48.3 & 5,400 & 70.1 \\
\hline
\end{tabular}
\footnotesize{Note: Figures rounded once calculations complete.}
\end{table}

2.5 Ethnicity

The ethnographic profile of Suffolk is currently in a phase of rapid change. The first major wave of international migration to Suffolk after 1945 originated mainly from India, Pakistan, Bangladesh, Africa and the Caribbean, and settled mostly in the Ipswich area. Over the years and up to the present, other groups of people have arrived to Suffolk seeking asylum, for example from Iraq and Kosovo. There are also around 12,000 American military, their contractors and their families currently based in USAF Mildenhall and Lakenheath (Forest Heath District) and are included in the subsequent analysis.

The 2001 Census\textsuperscript{19} shows that 18,448 people in Suffolk described themselves as black or from a minority ethnic background (BME); this is equivalent to 2.8\% of the population, which is only a third of the level for England as a whole. Figure 2.5 shows how the different black and minority ethnic groups are distributed across the County, with the highest percentages of people from these groups located in Ipswich and Forest Heath. The Census also shows that in 2001, 4.7\% of children aged 16 and under were
from a black or minority ethnic background, whereas more recent information suggests a figure of 8.35%\(^{21}\).

In addition to the black and minority ethnic groups described above, there were 19,257 white people who were not British or Irish living in Suffolk in 2001. These included other Europeans, Americans, South Africans, Gypsies, Romany, etc. Altogether, this means that 5.6% of the population in Suffolk at the time of the Census belonged to an ethnic group other than white British or Irish.

Figure 2.5: Ethnicity by District Area (Census 2001)

From 2004, there has been migration into Suffolk (and England) of people from the eight former Eastern Bloc countries and Bulgaria and Romania. When such immigrants live in the UK for one year or more, they are automatically classified as ‘residents’ and are included in both the population estimates and projections\(^{22}\). However those who stay here for a shorter period of time are excluded from these two suites of data despite their impact on the country’s economy.

Suffolk has a number of migrant workers who are not included in official population estimates or projections and of whom accurate statistics are not available. Data collected by the Department of Work and Pensions on the number of foreign nationals registering for a new National Insurance number (a necessary requirement for working in this country or claiming benefits) can be used as a proxy measurement for the number of people who intend to work in the UK or who have started work upon completion of their studies in this country. This data includes both “residents” and people staying in the country for a year or less. As there is no need to relinquish a national insurance number on departure no related data on the number of people who leave the country is available. Further work needs to be done in identifying the number of people who will return to their country of origin and how many will settle permanently in Suffolk.

\(^{21}\)Children and Young Peoples Directorate ‘Suffolk Assessment, 2006’. See section 4 for a demographic analysis of children and young people in the County.

\(^{22}\)UN definition.

Figure 2.6 shows that the number of foreign nationals registering for a National Insurance number has increased since 2002 in all of the districts and boroughs. During the latest tax year 2006/07 there were 4,980 new registrations by foreign nationals living in Suffolk, of which over a third came from Poland. In total, people from 43 different countries applied for National Insurance numbers during the last year.

During 2004/05, 57% of the National Insurance registrations by foreign nationals were made by men. The age profile of those registering during this period is skewed towards the younger end, with 74% being between 18 and 34 years old. Of the 3890 registrations made by foreign nationals, only 80 (2%) claimed some sort of benefit after six months, suggesting a high level of self sufficiency.

It has become apparent during the three years since 2004 that a number of community cohesion issues have arisen from the large number of new arrivals in both Suffolk and the UK. It will become increasingly important to develop plans and strategies in Suffolk that are inclusive of all these groups of people and which promotes community and social cohesion, both between the new arrivals and more established communities but also between the different communities of new arrivals. See Section 8 for an analysis of what the different ethnic groups in Suffolk say their needs, wants and aspirations are.

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Figure 2.6: National Insurance Registrations by Foreign Nationals by District/ Borough Council Area

23Department of Work and Pensions, 2007
Section 3: Health Needs

Interesting Facts...

- The main causes of death in Suffolk are circulatory disease, cancer and respiratory disease
- There are strong links between mental ill health and physical ill health as those with the former are 1.5 times more likely to die prematurely
- Between 25 and 40% of people learning disabilities also have mental health problems, which may mean that their disability is not recognised or diagnosed.

Key Issues:

- Fracture of the femur, heart failure and pneumonia are the main causes for emergency admissions to hospital for those aged over 85 years.
- Circulatory disease is the main cause of death in the UK and is responsible for 38.4% of all deaths in Suffolk.
- Deaths from coronary heart disease have fallen across Suffolk, but the fall has been more marked for men than for women.
- Death rates from accidents have not improved in Suffolk between 1993 and 2005.
- Mental ill health is strongly associated with a number of risk factors. Targeting these risk factors more explicitly and holistically may lead to a more effective approach.
- There is a projected rise of 62% by 2028 of people with dementia. Further analysis required of number nationally and at a Suffolk level.
- The significant gap between estimated and formally registered numbers of visually impaired people in Suffolk may suggest significant unmet need.

3.1 Mortality

The main causes of death amongst Suffolk residents are very similar to those for the rest of England and Wales, and although there is some variability between the local authority districts, these are not very marked. The main cause of death in Suffolk is circulatory disease, which accounted for 38.4% of all deaths in Suffolk and 37.2% of deaths in England and Wales between 2003 and 2005. This is followed by deaths from all cancers, which in Suffolk was 26.9% and in England and Wales 26.7%. Respiratory disease accounted for 12.7% of deaths in Suffolk and 13.9% in England. Deaths from all causes by age reflects the older age profile of Suffolk as a whole, with 36.6% of deaths occurring in those aged 85 years plus, compared with 32% in England and Wales. Between 2003 and 2005, only 13.7% of all deaths occurred to those aged under 65 years, which suggests that a large majority of the population will need at least some services for older people at some point in the future.
Death rates in the districts and borough council areas of Suffolk have changed between 1993 and 2005. The information below is presented as age-standardised mortality rates, (which means that the districts can be compared with one another even though their populations have different age and sex profiles), and as three year moving averages which evens out annual fluctuations due to relatively small numbers in any one district. At district level the numbers of deaths for some of these diseases are too small to show statistical significance, and so should be treated with great caution.

### 3.1.1 Deaths from all Causes

Standardised mortality rates[^24] for deaths from all causes have fallen consistently across England and Wales as life expectancy has increased. Figure 3.1 shows that rates for Suffolk have been consistently below those for England and Wales although the decline for women in Suffolk has been less marked than that for men. Death rates from all causes have been consistently above the Suffolk average for men in Ipswich and Waveney, and women in Forest Heath. Rates for men in Mid Suffolk, Suffolk Coastal and Babergh have been consistently below the Suffolk rate, suggesting overall better health in these districts.

[^24]: The difference in death rates between a particular group such as the over 85s in Suffolk of people and a reference population i.e. over 85s in England.

[^25]: Suffolk Primary Care Trust and the Office for National Statistics.

*Figure 3.1: Death from all causes – Age Standardised Mortality Rates[^25]*
Across Suffolk as a whole between 1993 and 2005, deaths from coronary heart disease have consistently been lower than deaths in England and Wales, and have fallen for both men and women (see figure 3.2). However, the fall in the death rate for women has been far less marked than that for men, so that the gap between them has narrowed considerably. The rates for women in Mid Suffolk, Ipswich, and St Edmundsbury have all matched the rates for England and Wales at some point during this time span, whereas for males this occurs on only one measure in Forest Heath. Rates for men in Waveney and Ipswich for coronary heart disease have been consistently above the rate for Suffolk as a whole, all the other districts have had rates above and below the Suffolk rate at some time. The data at district level needs to be treated with caution, but suggests that prevention and care for women with coronary heart disease in Suffolk needs to be more closely examined, and that although the situation has improved for men, particular attention needs to be given to the residents of Forest Heath, Waveney and Ipswich.

Figure 3.2: Death from Coronary Heart Disease – Age Standardised Mortality Rates

Suffolk Primary Care Trust and the Office for National Statistics.

3.1.3 Deaths from All Cancers

The fall in deaths from all cancers between 1993 and 2005 has been less marked than that for coronary heart disease. Again, the standardised mortality rates for both men and women in Suffolk as a whole have been consistently lower than the rates for England and Wales over this time period (see figure 3.3). The data at district level shows more fluctuations however, with only Ipswich consistently above the Suffolk rate, and Mid Suffolk and Suffolk Coastal consistently below it. Further analysis is required to identify which rates for specific cancers are rising and falling. This is because different cancers have different causes and disease patterns, and will require different care and treatment interventions. For example, work done by Dr Brian Keeble on mortality from cancer in Suffolk at electoral ward level, in 2005 could be revisited.

Figure 3.3: Death from All Cancers – Age Standardised Mortality Rates

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27Suffolk Primary Care Trust and the Office for National Statistics.
29Suffolk Primary Care Trust and the Office for National Statistics.
3.1.4 Deaths from Chronic Obstructive Pulmonary Disease

Age standardised death rates from chronic obstructive pulmonary disease are much lower than for either coronary heart disease or cancer, but it still represents a serious burden of disease for local residents, with a damaging effect on quality of life. Because the number of deaths at local authority level is so small, great caution is needed in interpreting these graphs.

Between 1993 and 2005, rates of death from chronic obstructive pulmonary disease have fallen across England for men, but for women have been more or less static. The rates for both males and females in Suffolk have been well below the rates for England and Wales throughout the period. Rates for males in Mid Suffolk and Suffolk Coastal have been consistently below the Suffolk rate, whilst the rate for females in St Edmundsbury and Forest Heath have been consistently above it, but the numbers of deaths in all cases is very small.

3.1.5 Deaths Rates from Accidents

Death rates from accidents appear static across England and Wales. In Suffolk the numbers of deaths from accidents is relatively small – in 2005 137 people died as the result of an accident in Suffolk – so very small differences in numbers in any one year can make a difference to the county rate, and thus have to be treated with caution. Across Suffolk, the death rates for males and females fell between 1997 and 2000, and then rose again, so that although they have flattened out again, the rate for men has risen above that for England and Wales. Suffolk County Council and Suffolk Police are currently investigating serious injury and deaths from accidents and their findings will be needed to complement this document.

3.2 Morbidity

In order to provide health and social care services effectively to meet need, and efficiently to meet levels of demand, we need to know what diseases or health problems our local populations are suffering from, the numbers of people affected, and where they are. Although we have good, reliable data about mortality and the diseases people die from, we have very little robust information about the burden of disability and ill health in our population at large. There is research data about specific illnesses and we are able to apply research models to our own population to predict the numbers locally who may be suffering from those diseases. We can use various proxy measures such as disability or illness related benefits, or numbers of prescriptions for drugs to treat particular diseases, but these will always underestimate the extent of these problems in our population. General practitioners are the front line of the health service for most people, and with their ‘cradle to the grave’ records can be expected to have the most comprehensive, if not the most detailed information about diseases prevalent in the community. They won’t have information about illness that people choose to treat themselves or ignore, and they won’t have the level of detail expected from hospital data, but it is the best that currently exists.
3.2.1 Disease Prevalence

The Quality and Outcomes Framework (QOF) was introduced with the new General Medical Services Contract as a way of measuring the achievement of general practices on a number of clinical and organisational indicators. The indicators of particular interest here are those related to specific diseases. This has required practices to maintain specific information about patients registered with them, who have been diagnosed with one of these diseases, and requires them to maintain disease registers for some of them. Prevalence is defined as the number of cases of a condition found within a defined population at a certain point in time, and the information from the Suffolk GP practice records have been used here to provide an estimate of the prevalence of a number of diseases in different areas of the County.

The prevalence rates presented here are based on the number of patients on the GPs’ disease registers, and the number of registered patients on their list. This takes no account of the different age profiles found in different practices or the different social characteristics of the different practice populations. The data here also depends on the quality and completeness of the GP records from which it was drawn, and although that is improving, it is still uncertain. The data here conforms to the definitions of the diseases required by the QOF system, which may not be the definitions that would be chosen for clinical or other purposes. Although this data has its limitations, it can still be used as a good starting point for needs assessment.30, 31

Suffolk has a higher burden of disease than England for most diseases in QOF 2005/2006. This most likely reflects the fact that Suffolk in general has an older population than the rest of the Country. In six out of the 11 diseases covered the old Waveney primary care trust has the highest unadjusted prevalence in Suffolk. Again, this probably reflects the older population of Waveney compared to the rest of Suffolk.

As a comparative assessment of need, people on the CHD or stroke registers might be used as a proxy to consider the health burden for an area due to circulatory conditions. Similarly, people registered as having COPD or asthma might be used as a proxy to consider the health burden for an area due to chronic respiratory conditions. If chronic respiratory conditions are well managed in primary care or the community then emergency admissions (and associated costs) due to these conditions should be reduced. As a further example, people on cancer registers might be used as a proxy to consider the health burden for an area when providing end of life care.

The Effect of Age

As one might expect, to a greater or lesser extent, age distribution appears to be an explanatory factor in the different prevalence rates of some of the QOF chronic disease categories experienced by primary care trusts in Suffolk. The diagram below shows that much of the variation in disease prevalence is explained by variation in the percentage of people aged 65 and over. In all these cases it appears that as the elderly population

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30Paul Bingham 2006 INphoRM 7: An introduction to Quality and Outcomes Framework data; an introduction to QOF data covering the types of data available, the level of detail and the future potential of the dataset. ERPHO.
increases the disease prevalence increases. This will have impacts on service demand in Suffolk; with its increasingly ageing population.

**Figure 3.4: Selected QOF disease unadjusted prevalence vs. % population aged 65 and over for old PCTs in Suffolk 2005/2006**


One might expect deprivation to be a factor in disease prevalence but this does not appear to be the case here. The data shows no association between the unadjusted prevalence of coronary heart disease or diabetes, and the indices of multiple deprivation 2004 area income scores.

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32Suffolk Primary Care Trust and the Office for National Statistics.
Mental Health

Research carried out by the Suffolk Primary Care Trust in 2006[^33] found that, nationally, around 17%, or 1 in 6 of adults has a mental health problem, and there are currently more people drawing incapacity benefit because of mental ill health than the total number of unemployed on Jobseekers Allowance. There are also strong links between mental ill health and physical ill health as those with the former are 1.5 times more likely to die prematurely.

In the Suffolk PCT area, the expected numbers of people suffering from a mental health problem every year is 147,000-178,000. Of these people, 130,000 will attend primary care, 57,000 will have been identified by their GP as having a mental health problem, 12,000 will be referred to a specialist psychiatric service and 2,900 will be referred to a psychiatric hospital. These figures do not include people in Waveney, so the numbers are likely to be much higher for the whole of Suffolk.[^34]

The type of mental health problems found in the population is estimated by the Psychiatric Morbidity Survey. Table 3.1 gives the national prevalence rates for different types of mental illness occurring in participants in the 2000 survey.

| Table 3.1: National Figures for those with Different Types of Mental Illness |
|---------------------------------|----------|----------|
| Rate per 1000 of population    | All      | Women    | Men      |
| Generalised anxiety            | 4.4      | 4.6      | 4.3      |
| Depressive episode             | 2.6      | 2.8      | 2.3      |
| Phobias                        | 1.8      | 2.2      | 1.3      |
| Obsessive compulsive disorder  | 1.1      | 1.3      | 0.9      |
| Panic attacks                  | 0.7      | 0.7      | 0.7      |
| Psychosis (inc. schizophrenia)| 0.5      | 0.5      | 0.6      |
| Other (mixed depression/anxiety)| 8.8   | 10.8    | 6.8      |

The figure above suggests that the prevalence of mental ill health in the Suffolk PCT area is likely to be far higher amongst women than men, particularly for phobias where the figure is 2.2 for women and 1.3 for men.

The national survey indicated that those groups with the following characteristics (risk categories) were more likely to have a neurotic or psychotic disorder when compared with those with no mental problem:

- Those with no formal qualifications
- Economically inactive

[^33]: Dr. Amanda Jones "Mental Ill Health: Effects on the Population of East and West Suffolk" Director of Public Health Annual Report 2006.
[^34]: Dr Amanda Jones, 2006 and Mental Health Vision for Suffolk, Suffolk County Council and partners, 2007.
Lower social classes
Those who rent a property
Live in urban areas with higher levels of multiple deprivation

Those with severe mental ill health also have higher prevalence of smoking and alcohol consumption, low levels of exercise and poor diet. This results, for instance, in between 40% and 62% of those with Schizophrenia being overweight or obese.

The Psychiatric Morbidity Survey also found that differences also exist in the prevalence of mental health problems between ethnic groups.

Table 3.2: Mental Illness Admissions to Psychiatric Hospital by Ethnicity

<table>
<thead>
<tr>
<th>Ethnic Group</th>
<th>2001 Census (Suffolk PCT)</th>
<th>SMHPT Admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>97.2</td>
<td>94.3</td>
</tr>
<tr>
<td>Mixed</td>
<td>1.1</td>
<td>1.2</td>
</tr>
<tr>
<td>Black</td>
<td>0.7</td>
<td>1.9</td>
</tr>
<tr>
<td>Asian</td>
<td>0.6</td>
<td>1.2</td>
</tr>
<tr>
<td>Other</td>
<td>0.5</td>
<td>1.5</td>
</tr>
</tbody>
</table>

The figure above suggests that prevalence of mental ill health amongst the non-white population may be disproportionate compared to their profiles in the Suffolk PCT area. This is especially true of those who class themselves as being from black ethnic backgrounds (although this finding was not significant due to small numbers).

Suffolk County Council and the two Primary Care Trusts in Suffolk are carrying out a mental health needs analysis which will be completed in December 2007. This work will include a mapping of current provision (excluding supported housing) and looking at population forecasts. The findings from this work will inform the next JSNA.

Dementia

Research published by the Alzheimer’s Society in 2007 forecast a rise of 45% in cases of dementia in England over the next 15 years\(^\text{35}\). This research is supported by work carried out in Suffolk by district area into the prevalence of dementia over the next 20 years. Not surprisingly, there is a strong relationship between the projected growth in the elderly population and the rise in Dementia. Whilst Ipswich will increase from 1700 to 2400 cases by 2028 (41% increase), Mid-Suffolk will go from 1400 to 2600 (86%). The overall picture for Suffolk seems to be worse than for the region as a whole, with a 62% forecast increase for the County by 2028. The following chart shows the increases in projected dementia levels covered by Suffolk Mental Health Partnership Trust. There will be direct resource and service delivery implications for agencies in Suffolk in dealing with this issue.

\(^\text{35}\)http://www.alzheimers.org.uk/news_and_campaigns/Press_Releases/m_080607_DUK_eastanglia.htm

Although the exact figures are not known, it is estimated that between 1% and 3% of the population has a mild learning disability based on national prevalence figures\(^{36}\) and that between 0.4 and 0.6% of the population has a severe learning disability, although approximately 0.2% are hidden and do not use learning disability services. It is also estimated that between 25% and 40% of those with learning disabilities also have mental health problems, which may mean that their disability is not recognised or diagnosed. Based on these national-level statistics, it is estimated that there are between 5000 and 15,200 adults in Suffolk with a mild learning disability, and between 2000 and 3000 adults with a severe learning disability.

Suffolk Family Carers carried out research in 2006/07 looking at adults from black and ethnic minorities who have learning disabilities.\(^{37}\) It estimated that there are between 140 (1%) and 420 (3%) adults from black and minority ethnic groups with a mild learning disability and 55 (0.4%) and 84 (0.6%) adults with a severe learning disability in Suffolk. It should be noted that there is a higher incidence of learning disabilities in people from South Asian communities, of whom there are approximately 3000 in Suffolk (2001 Census), two thirds of whom reside in Ipswich.\(^{38}\)

There are approximately 1,900 adults with learning disabilities who receive a service from Suffolk County Council’s Adult and Community Services. Given the upper estimate of 15,200 adults with some level of learning disability in Suffolk, this means that there

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\(^{38}\)A Place for Me”, Ridgeway Associates, January 2005.
are potentially 13,300 adults in the county who may not be receiving the services they need and may benefit from.

### Physical Disabilities

The government does not collect comprehensive information on those with physical disability and there is not a question relating directly to disability in the 2001 Census. Nationally however it is estimated that 20% of the population fall within the Disability Discrimination Act definition of having a disability, equating to approximately 10 million people in the United Kingdom and 140,000 people in Suffolk. 8000 individuals are listed on Suffolk County Council’s database of service users as having a physical disability. Information available on those with a physical disability should be considered a major gap in knowledge and further research is needed to determine the nature of the issue in Suffolk.

### Sensory Disabilities

The majority of those with sensory difficulties in Suffolk, including deaf, blind and deaf blind people live in the urban hubs of Suffolk, including Ipswich, Lowestoft and Bury St. Edmunds. There is currently a waiting list for those with a visual or dual impairment to see a rehabilitation officer from the sensory team based at Suffolk County Council. As sensory support is offered in a demand-responsive manner (i.e. according to need), all age groups, genders and ethnicities are dealt with – the oldest customer at present is 106 years old.

Figures published by the Royal National Institute for the Deaf (RNID) estimate that in the UK there are 9 million, or 1 in 7 of the total population with mild to profound hearing loss rising to 1 in 3 amongst older people. This means that there are an estimated 114,000 people in Suffolk with some level of hearing loss.

The Royal National Institute for the Blind (RNIB) estimates that in the UK there are 2 million people with sight loss. This equates to 25,000 people in Suffolk, although only 3-5000 are registered as blind or partially sighted. This discrepancy between estimated and actual figures may suggest a significant gap between the supply of sensory services to visually impaired people and the need of this group.
Section 4: Health and Social Care

Interesting Facts . . .

- There are 66,133 unpaid family carers in Suffolk according to the 2001 census.
- Average length of hospital stay following an emergency admission increases with age.
- For the major disease categories of cancers, circulatory disease and respiratory disease, men have higher emergency hospital admission rates than women, in all the Suffolk districts.
- The top 10 diagnoses in the 70 to 74 year age group only account for 33% of all emergency admissions, and in the 85 plus group, 42% of all emergency admissions.
- For respiratory disease emergency admissions, Ipswich has the highest rates in the county.
- The average length of hospital stay for the top 10 diagnoses increases with every 5 year age band from 1 to 4 years to 85 years plus, from 1.1 days to 8.6 days.

Key Issues:

- How to meet the increasing needs of the growing elderly population over the coming years in an equitable and sustainable manner, particularly with respect to care and accommodation needs.
- How to meet the diverse needs and demands of a growing number of unpaid family carers in Suffolk, which will increase with the growth in the elderly population.
- The Supporting People Strategy has identified gaps in services to specific client groups, notably refugees and people with HIV/AIDS that will need to be considered. It has also identified the need to look at the level of access to current services in relation to specific client groups, such as black and minority ethnic groups.
- Fracture of the femur, heart failure and pneumonia are the main causes for emergency admissions to hospital for those aged over 85 years.
- Health service and health professionals, local authorities, the private and voluntary sectors, need to ensure that information and services to promote healthy living are accessible and acceptable to all members of the community who could benefit.
- The Draft East of England Plan has identified 58,600 (2,930 per year) more homes to be built in Suffolk by 2021. This will have an impact on health and social care demand levels and will need to be factored into capacity and strategic plans.
- The changes in the demographic profile of Suffolk outlined in Section 2, together with the changing expectations of customers and changes in government policy e.g. Patient Choice and individualised budgets have some potentially wide-ranging implications for the provision of health, social care and well being services and amenities in Suffolk over the next few years.
4.1 Commissioning for Health and Social Care

The services and developments commissioned by the two Primary Care Trusts and the County Council in Suffolk are changing in order to be more responsive to the needs of the population, and to reflect government policy. People want to have more control and independence, more choice in their care services, and want services to be delivered closer to home.

Suffolk Primary Care Trust’s Strategic Plan (“Commissioning for Health”) identifies a number of important national policy initiatives which influence the development of local services for primary care trusts including:39

- A drive for improvements in access to services including reducing waiting time and increasing access to primary care services - particularly for GP services at times convenient to patients.
- Increased levels of choice for patients about when how and where they are treated – with money following the patient as they exercise that choice.
- Better use of and increased levels of investment in information technology – improving the flexibility and quality of services to patients.
- Better use of new treatment technologies and new medicines. with better clinical productivity
- Strong focus on health improvement to help people mange their health and wellbeing including a focus on supporting people with long term health conditions.
- Addressing the marked inequalities in health that exist currently.
- Increasing the level of local accountability of health services – putting local people in a stronger position to influence healthcare and the way it is provided by for example establishing membership organisations like foundation trusts.

Within Suffolk County Council, the Adult and Community Services (ACS) directorate has responsibility for improving the health and well being of Suffolk residents. It brings together adult social care with culture, information, libraries and community learning in order to assist people to develop and sustain their economic, health and social well being. Some of the key initiatives for Adult and Community Services are to:40

- Develop a market that is able to respond to the demands of self directed support and individual budgets
- Improve access to services
- Put a strong focus on providing better information about choices and entitlements
- Develop everyday services that are accessible to individuals with ill health and disabilities
- Increase use of art and leisure activities in the prevention of physical and mental ill health
- Use assistive technologies to help people remain at home.

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4.2 Current Provision

4.2.1 Adult Social Care

Appendix 3 shows how the Directorate’s budget was spent in 2006/07. During this period, over half (54%) of its budget was spent on services for older people, such as residential homes, domiciliary care and day services. In the context of national policy and as part of its vision, the Adult Community Services budget is moving away from these more traditional services towards self directed support and individual budgets.

Approximately 15,600 customers currently receive Adult Social Care services. These services are either provided directly by the Council, or by independent sector providers. Figure 4.1 shows the main type of services provided to customers:41

The following sections outline some of the services currently being funded or partly funded by Adult and Community Services and partners. However, it should be noted that changing populations, increased customer expectations and the lifestyle issues identified in this analysis will all have an impact on the way services are delivered and by whom. The challenge for Suffolk will be to find the right balance of services that promote independence at home, offer supported accommodation for those that need it and to ensure that sufficient care home places are available for those with complex needs. All this whilst the County is undergoing a significant demographic change, as outlined in Section 2.

41Those customers in a care home and attending a day care centre are only counted as a care home customer; customers receiving and attending a day care service are only counted as receiving domiciliary care. Customers receiving other services such as meal services have been excluded from these figures.

42Customers receiving Supporting People services are funded through the Supporting People Grant (see Housing Support section in page 34).
The Commission for Social Care Inspection figures in Table 4.1 below show the number of care home places registered in Suffolk compared to England as a whole:43

Table 4.1: Number of Care Home Places Registered in Suffolk and in England per 1000 of the Total Population

<table>
<thead>
<tr>
<th>User Group</th>
<th>Suffolk</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Older People*</td>
<td>31.50</td>
<td>35.10</td>
</tr>
<tr>
<td>Dementia &gt;65*</td>
<td>10.76</td>
<td>12.03</td>
</tr>
<tr>
<td>Learning Disability**</td>
<td>1.41</td>
<td>1.56</td>
</tr>
<tr>
<td>Mental Health**</td>
<td>0.27</td>
<td>0.74</td>
</tr>
<tr>
<td>Physically Disability**</td>
<td>0.5</td>
<td>1.19</td>
</tr>
<tr>
<td>Sensory Disability**</td>
<td>0</td>
<td>0.09</td>
</tr>
</tbody>
</table>

* per person 65 and over, ** per person 18-64

In each category the numbers of places are lower in Suffolk than across England. One contributing factor to this is the success Suffolk has had in developing alternatives to residential care in the form of supported housing and very sheltered housing. In Suffolk supported housing is an essential element of the accommodation mix and means that Suffolk is not as dependent on residential care for individuals with complex needs as many other counties (See section on Housing Related Support below).

From April 2006 to April 2007 the numbers of people in care homes has fallen overall by 5.1% because the priority is to help people live at home, but the number in dementia care places have increased by 31% over the same period.

Suffolk County Council provides 17 homes with a total of 569 places and purchases an additional 2744 places in the independent market.

Figure 4.2 shows that the majority of spaces are currently found in the urban hubs of Ipswich, Lowestoft and Bury St. Edmunds with smaller centres in Stowmarket, Sudbury, Leiston and Beccles. Numerous other homes are distributed throughout the County.

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43CSCI Market Analyser 2006.
Home Care Services

Suffolk County Council supports 4128 people at home by providing home care services either directly or through external providers. It also provides a 12 week assessment and re-enablement service (“Home First”) that helps approximately 600 customers with short term care to enable them to live at home.

Housing Related Support

Housing related support are services that help people live independently in their own home or that help vulnerable adults to acquire the necessary skills to live independently. Supporting People in Suffolk receive an £18 million grant from central government to fund these types of services. Suffolk County Council manages this grant on behalf of all Supporting People partners including district councils, primary care trusts and the probation service.

The following table shows that the majority of housing units supported by Supporting People are for older people. However, it also has an important role in providing support to marginalised adults – a group of people who generally fall outside the statutory system when it comes to getting services. Typically these people will be homeless and/ or difficult to deal with and/or transient and/or unable to access normal support systems. Another reason for people being marginalised is that they face barriers to accessing services because of language or culture issues.

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*Supporting People Annual Plan (2007).*
*Marginalised Adults Manifesto, Marginalised Adults Partnership Board (Suffolk).*
The supported housing services provided in Suffolk include shared living schemes for young people such as care leavers, schemes for young teenage parents, temporary homelessness accommodation for families and single people, schemes for offenders, accommodation for people who have substance misuse issues and a range of support services that can go to wherever people need the service.46

The Supporting People Strategy has identified gaps in services to specific client groups, notably refugees and people with HIV/AIDS that will need to be considered. There are also no specific services for black and minority ethnic groups, and whilst this may not be required, there is a need to look at the level of access to current services in relation to specific client groups. For instance, there are a disproportionate number of black British in the ex-offender category.

Table 4.2: Number of housing units supported per client group

<table>
<thead>
<tr>
<th>Client Group</th>
<th>Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Older People with support needs</td>
<td>6,199</td>
<td>68</td>
</tr>
<tr>
<td>Single homeless with support needs</td>
<td>705</td>
<td>7.7</td>
</tr>
<tr>
<td>Frail elderly</td>
<td>634</td>
<td>7.0</td>
</tr>
<tr>
<td>People with Mental Health Problems</td>
<td>312</td>
<td>3.4</td>
</tr>
<tr>
<td>Generic</td>
<td>270</td>
<td>3.0</td>
</tr>
<tr>
<td>People with Learning Disabilities</td>
<td>261</td>
<td>2.9</td>
</tr>
<tr>
<td>Homeless Families with Support Needs</td>
<td>200</td>
<td>2.2</td>
</tr>
<tr>
<td>Young People at Risk</td>
<td>128</td>
<td>1.41</td>
</tr>
<tr>
<td>People with a Physical or Sensory Disability</td>
<td>101</td>
<td>1.11</td>
</tr>
<tr>
<td>Women at Risk of Domestic Violence</td>
<td>56</td>
<td>0.64</td>
</tr>
<tr>
<td>Teenage Parents</td>
<td>56</td>
<td>0.62</td>
</tr>
<tr>
<td>Travellers</td>
<td>55</td>
<td>0.60</td>
</tr>
<tr>
<td>Offenders or People at risk of Offending</td>
<td>54</td>
<td>0.59</td>
</tr>
<tr>
<td>People with Drug Problems</td>
<td>28</td>
<td>0.31</td>
</tr>
<tr>
<td>Young People Leaving Care</td>
<td>17</td>
<td>0.19</td>
</tr>
<tr>
<td>Mentally Disordered Offenders</td>
<td>12</td>
<td>0.13</td>
</tr>
<tr>
<td>Older People with mental health problems/dementia</td>
<td>8</td>
<td>0.09</td>
</tr>
<tr>
<td>People with Alcohol Problems</td>
<td>5</td>
<td>0.05</td>
</tr>
</tbody>
</table>

Sheltered Housing

Sheltered housing is specially designed or adapted accommodation for older people who are able to live independently but would like the benefits of a daily visit from a warden and an alarm to summon help in an emergency. For the purposes of the JSNA, the definition for sheltered housing is:47

**Category 1:** May only have a community alarm service and communal facilities are optional, or part time warden normally five days a week with out of hours covered by community alarm.

**Category 2:** Communal facilities are usually provided and a warden/ scheme manager may or may not be resident. Normally seven-day service covered by peripatetic or other warden, with any out of hours covered by community alarm.

**Category 2 1/2:** This is very sheltered housing where a minimum of four hours care is provided for the older person, which may be up to twenty four hours a day, seven days a week. Some very sheltered housing may have “extra care” with special support provided within the scheme (for people with dementia or functional mental ill health). The aim of very sheltered housing48 is to maximise the independence of older people by providing tenanted and self-contained accommodation and 24-hour care and support, which is tailored to the needs of the individual.

In 2005 there were 7936 sheltered housing units in Suffolk for older people. Table 4.3 shows that only 7% of the sheltered housing stock (577) was very sheltered, and of these, 11% (65 units) provide extra care with specialist support.

An audit of very sheltered housing stock in Suffolk carried out in March 200749 shows that there has been an increase in the number of very sheltered housing units in Suffolk since 2005 (from 577 to 704), either through new build, or as a result of converting category 1 or 2 sheltered housing into very sheltered housing. Of the 704 units, 14% (97 units) provide extra care with specialist support. Since 2005, the following very sheltered housing schemes have been built:

- Steeple View (Mid Suffolk): 28 very sheltered and 8 extra care units
- Mere View (Mid Suffolk): 32 very sheltered units
- Ixworth Court (St. Edmundsbury): 25 very sheltered and 8 extra care units
- Exning (St. Edmundsbury): 26 very sheltered and 8 extra care units

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47 County Wide Review of Sheltered Housing (2006), Part B: Collected Data and Reference Sources.
49 VSH Stock List March 2007, Suffolk County Council and Suffolk Supporting People.
The Commission for Social Care Inspection report, “The State of Social Care In England 2005-06”\textsuperscript{51} described support for carers as “one of the biggest public policy challenges of our time”. Supporting family carers is important because it enables them to attend to their own health and lifestyle needs, such as access to employment, leisure or education opportunities.

According to the 2001 Census, there are 66,133 unpaid family carers of all ages in Suffolk, comprising just under 10% of the total population. The Census figures include 32 children aged between 5 and 9 who provide between 20 and 50 hours care per week and 127 children aged between 10 and 15 providing the same amount of care\textsuperscript{52} (See also “Young Carers” in Section 5). There are 18,842 carers who provide over 20 hours of care a week, including 64 who are over 90 years old. Figure 4.3 below shows the areas in Suffolk with the highest number of family carers, taken from the 2001 census.

There is a statutory duty on all local authorities to inform family carers about their right to an assessment and for the local authority to carry out such an assessment when requested. When carrying out the assessment the local authority must consider the needs of the family carer in their own right as well as in relation to their caring role. This means the assessment must take in to account the family carer’s own unique lifestyle aspirations, with particular regard to employment, education and leisure when determining a package of services for the cared for person. The nature of this assessment means that demand for carers’ services is increasing, and is expected to continue to increase. Some of the other factors contributing to an increase in demand are:

\textsuperscript{50}County Wide Review of Sheltered Housing (2006), Part B: Collected Data and Reference Sources.
\textsuperscript{51}Published December 2006 by the Commission for Social Care Inspection (reference CSCI 186).
\textsuperscript{52}See the Suffolk Assessment 2006 for more details on the needs of children in Suffolk.

Table 4.3: Sheltered and Very Sheltered Housing in Suffolk 2005

<table>
<thead>
<tr>
<th>Council</th>
<th>Sheltered (Categories 1 and 2)</th>
<th>Very Sheltered</th>
<th>Very Sheltered with Extra Care</th>
<th>Total Stock</th>
</tr>
</thead>
<tbody>
<tr>
<td>Babergh</td>
<td>637</td>
<td>97</td>
<td>0</td>
<td>734</td>
</tr>
<tr>
<td>Forest Heath</td>
<td>534</td>
<td>40</td>
<td>8</td>
<td>582</td>
</tr>
<tr>
<td>Ipswich</td>
<td>1477*</td>
<td>146</td>
<td>16</td>
<td>1639</td>
</tr>
<tr>
<td>Mid Suffolk</td>
<td>971</td>
<td>0</td>
<td>0</td>
<td>971</td>
</tr>
<tr>
<td>St Edmundsbury</td>
<td>1032</td>
<td>45</td>
<td>8</td>
<td>1085</td>
</tr>
<tr>
<td>Suffolk Coastal</td>
<td>1218*</td>
<td>140</td>
<td>16</td>
<td>1374</td>
</tr>
<tr>
<td>Waveney</td>
<td>1490*</td>
<td>44</td>
<td>17</td>
<td>1551</td>
</tr>
<tr>
<td>Suffolk</td>
<td>7359</td>
<td>512</td>
<td>65</td>
<td>7936</td>
</tr>
</tbody>
</table>

* These figures include 117 units, which are not category 1 or 2 sheltered housing, but other sheltered housing models.
More people with a severe learning disability or other previously life-limiting condition are living longer and remaining in the community with very complex needs.

Increased life-expectancy means some very elderly couples are caring for each other.

The over 65 population for the County is forecast to increase by 49% between 2001 and 2021. The over-85 population is forecast to increase by 90%.

Raised expectations by family carers regarding their own careers and life-styles, particularly for women, who increasingly have a dual role as both family carers and active (often part-time) workers in the economy (Benington, 1998).

Families are now much more geographically dispersed and fragmented so that members no longer live near each other or have the time to help out.

A significant move over recent decades away from institutional care in all forms, including minimising the length of in-patient hospital care.

The respite care provided by health services on their own sites, for example for people with severe learning disabilities, is being transferred to Suffolk County Council for community provision in line with the objective of promoting inclusion and achieving ordinary lives.

An increasingly diverse community means that services have to be increasingly flexible to ensure that they respond to the needs of people from all cultural and religious backgrounds.

Figure 4.3: Numbers of Family Carers in Suffolk 2001 Census
Primary Care Trust Services Commissioned in Suffolk

Suffolk Primary Care Trust and Great Yarmouth Primary Care Trust are responsible for:

**Improve Health and wellbeing:** working with local authorities and other partners to reduce health inequalities, improve the health and wellbeing, develop sustainable communities, protect health and contribute to civil emergency planning.

**Commission Healthcare Services:** working with practice based and other specialist commissioners to plan and secure high quality, safe and responsive services which meet the needs of local people. This includes acute hospital services, specialist clinical services, mental health services, NHS funded Continuing care beds, dentists, GPs and other community healthcare services.

**Directly Provide Community Healthcare Services:** local community healthcare services are delivered through a Provider Unit which, whilst part of the PCT, act as an arms length organisation to provide a range of services including managing community hospitals, local healthcare teams, district nurses, therapist and other health services such as podiatry and community dentistry.

The two Primary Care Trusts commission a full range of primary, intermediate, secondary, emergency, and mental health care services to the people of Suffolk through:

Table 4.4: Services Commissioned by Suffolk PCT and Great Yarmouth and Waveney PCT

<table>
<thead>
<tr>
<th>Service</th>
<th>Suffolk PCT (numbers)</th>
<th>Great Yarmouth and Waveney PCT (numbers)</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP practices (with some branch surgeries)</td>
<td>69</td>
<td>35</td>
</tr>
<tr>
<td>Dental Practices</td>
<td>80</td>
<td>28</td>
</tr>
<tr>
<td>Pharmacies</td>
<td>88</td>
<td>47</td>
</tr>
<tr>
<td>Optician Practices</td>
<td>122</td>
<td>26</td>
</tr>
<tr>
<td>Community Hospitals</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Acute General Hospital</td>
<td>2*</td>
<td>2*</td>
</tr>
<tr>
<td>Mental Health Partnership Trust</td>
<td>1 (includes learning disability)</td>
<td>1</td>
</tr>
<tr>
<td>District nursing/intermediate care service</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Prison health care service</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Podiatry services</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Health visitors</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>School nursing services</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Specialist children community nursing, speech and language, occupational, and physiotherapy therapy</td>
<td>√</td>
<td>√</td>
</tr>
</tbody>
</table>

*Suffolk PCT Strategic Plan, 2007.*
Appendix 3 shows a spend analysis by top 10 areas of expenditure during 2006/07 for both Primary Care Trusts in Suffolk.

### 4.2.3 Health Care Activity

A review of the reasons people in Suffolk have received hospital care in the last five years is not so much an indicator of the need for hospital services, but of the illnesses which bring individuals to crisis point, the frequency with which that is happening, and the resources currently being used. This knowledge can then be used to help identify the most vulnerable groups in Suffolk and to redesign care pathways to better suit their specific needs.

#### Top Ten Diagnoses Causing Emergency Admissions

This section reports on the top ten diagnoses consuming the most bed days for Suffolk residents. These seemingly simple headings conceal highly complex data, and the information presented in this document is only a first review, and will need to be supplemented by detailed and focused analysis of the use of hospital facilities in Suffolk.

The Hospital Episode statistics needed for this analysis was provided by the Eastern Region Public Health Observatory. The diagnoses are classified using the World Health Organisation International Classification of Diseases version 10 (ICD 10). Age, sex and diagnosis certainly have a bearing on the use of hospital facilities, and it was expected that place of residence and relative deprivation would also have an influence. In order to be able to look at trends for some illnesses and because numbers of admissions for some conditions are relatively small, data for Suffolk from the years 2001/02 to 2005/06 has been looked at. Different types of admissions are also examined, including emergency, elective, day case and ‘other’ admissions. This has proved to be problematical, as in some cases, the same events are classified differently by the three Suffolk hospitals and other tertiary units.

From this complexity it has been decided to report here on ‘persons’ rather than males and females separately (except where that does not make sense), for the youngest and oldest age groups, using the grouped data for the whole five year time span, with the
major life threatening conditions, and concentrating on emergency admissions (with a few exceptions). Data has not been analysed at a geographical level lower than local authority district.

**Top Ten Diagnoses Causing Emergency Admissions in the Younger Age Groups**

The Hospital Episode statistics show that for the youngest group – those under the age of one year, the most common causes of emergency admission to hospital are acute respiratory tract infection, gastro intestinal infection, or other breathing or feeding problems. It should be noted however that in this group these ten diagnoses account for only 53% of the total emergency admissions.54

In the age group 1 to 4 years, all the top ten diagnoses are related to respiratory tract disorders including asthma, and account for 50% of all emergency admissions in this group.

In the 5 to 19 years age groups the most frequent diagnoses are abdominal pain, appendicitis, fractured arms and legs and head injuries. In the top ten diagnoses of the 5 to 9 years group there is also asthma, respiratory infections and viral infections, and epilepsy, but by 10 to 14 years, infections and epilepsy are replaced by insulin dependent diabetes and (paracetamol) poisoning. In the 15 to 19 years age group paracetamol is joined by poisoning by psychotropic drugs, and spontaneous abortion and maternity care, and from 20 years to 34 years pregnancy related diagnoses account for 4 or 5 of the top 10 diagnoses in each 5 year age band.

**Top Ten Diagnoses and Emergency Admissions in Mid-Life**

In the age groups from 35 years to 49 years, pain in throat and chest, and abdominal and pelvic pain, headache, and poisoning with psychotropic drugs continue to feature in the top 10 diagnoses. Also from 35 years onwards is ‘other soft tissue disorders’ (eg myalgia). From 40 years onwards, angina pectoris is present in the list, and acute myocardial infarction from age 45 years onwards. Atrial fibrillation and atrial flutter appear from 50 years onwards, as does pneumonia. ‘Other chronic obstructive pulmonary disease first becomes one of the top 10 causes of emergency admission in the 55 to 59 year age group, and then disappears after age 84 years.

**Top Ten Diagnoses and Emergency Admission in the Older Age Groups**

From age 70 years onwards, circulatory diseases, pneumonia, chronic obstructive pulmonary disease and abdominal pain are in the top ten. From age 75 years onwards, fractured femur and ‘syncope and collapse’ are causes of emergency admission. It should be noted however, that these top 10 diagnoses in the 70 to 74 year age group only account for 33% of emergency admissions, and in the 85 plus group, 42%.

The top 10 diagnoses for elective admissions throughout middle and older age include planned care for the most common cancers. All these findings are unsurprising, and chart people’s life course, with the diseases most commonly responsible for mortality in the local population, appearing in the oldest age groups.
Table 4.5: Top 10 diagnoses of emergency admissions for over-55s 01/02-05/06

<table>
<thead>
<tr>
<th>Diagnosis description</th>
<th>Bed days</th>
<th>Length of Stay (as % of total)</th>
<th>No. of Diagnosis</th>
<th>(days)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fracture of femur</td>
<td>18107</td>
<td>7.27%</td>
<td>1335</td>
<td>13.6</td>
</tr>
<tr>
<td>Heart failure</td>
<td>14852</td>
<td>5.96%</td>
<td>1569</td>
<td>9.5</td>
</tr>
<tr>
<td>Pneumonia, organism unspecified</td>
<td>14624</td>
<td>5.87%</td>
<td>1513</td>
<td>9.7</td>
</tr>
<tr>
<td>Other disorders of urinary system</td>
<td>10103</td>
<td>4.05%</td>
<td>1042</td>
<td>9.7</td>
</tr>
<tr>
<td>Senility</td>
<td>8155</td>
<td>3.27%</td>
<td>877</td>
<td>9.3</td>
</tr>
<tr>
<td>Unspecified acute lower respiratory infection</td>
<td>7470</td>
<td>3.00%</td>
<td>830</td>
<td>9.0</td>
</tr>
<tr>
<td>Cerebral infarction</td>
<td>5674</td>
<td>2.28%</td>
<td>482</td>
<td>11.8</td>
</tr>
<tr>
<td>Other chronic obstructive pulmonary disease</td>
<td>5432</td>
<td>2.18%</td>
<td>580</td>
<td>9.4</td>
</tr>
<tr>
<td>Acute myocardial infarction</td>
<td>5380</td>
<td>2.16%</td>
<td>631</td>
<td>8.5</td>
</tr>
<tr>
<td>Atrial fibrillation and flutter</td>
<td>4995</td>
<td>2.00%</td>
<td>634</td>
<td>7.9</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>249215</td>
<td><strong>100%</strong></td>
<td><strong>28820</strong></td>
<td><strong>8.6</strong></td>
</tr>
</tbody>
</table>

Top Ten Diagnoses by Length of Stay in Hospital

Using the same groupings as for top 10 causes of admission, the following analysis looks at the top ten diagnoses by length of stay. It should be noted that the average length of stay for these top 10 diagnoses increases with every 5 year age band from 1 to 4 years to 85 years plus, from 1.1 days to 8.6 days.
Length of Stay for Youngest Age Groups

In the under 1 year group, respiratory problems and feeding difficulties were the diagnoses accounting for the longest stays, with bronchitis responsible for 17.7% of the total emergency admission length of stay in that group. In the 1 to 4 years age group, acute upper respiratory tract infections accounted for 5.5% of length of stay, and asthma for 5.2%, and convulsions for 3.7%. Fractured femur caused the longest average length of stay of 12.8 days, but the overall average length of stay was only 1.6 days. Diabetes as a main diagnosis is only in the lists of the 10 to 14 and 14 to 19 age groups, presumably in those newly diagnosed and still learning to manage the illness.

In the 10 to 14 years age group, acute appendicitis accounted for the most bed days (10.1%), with similar diagnoses to the top 10, except that this group included agranulocytosis and an average length of stay of 13.3 days for eating disorders and 4.9 days for cystic fibrosis.

Diagnosis and Length of Stay for Young Adults

Whereas the top diagnosis for young adults included a number of pregnancy related conditions, these are absent from the list of top 10 diagnoses and greatest numbers of bed days. In their place are cholelithiasis, schizophrenia, and other mental disorders. Abdominal and pelvic pain is top of the list from the 15 to 19 years to the 45 to 49 years age groups, and appears in all the groups from 5 to 9 years, to 60 to 64 years. Acute myocardial infarction appears in all the lists from age 40 years onwards, with an average
length of stay ranging from 5.1 days to 8.5 at 85 years plus. Fracture of the lower leg is in all the 5 year age bands from 10 to 14 to 55 to 59 years, and then from 65 to 69 years fracture of the femur appears in each age group as a top 10 length of stay, causing an average length of stay ranging from an average of 11 days to 13.6 at age 85 plus years. Alcoholic liver disease is in the top ten diagnoses and length of stay only for the age groups from 44 to 49 years and 55 to 59 years. Cellulitis appears in these middle years as a top ten length of stay.

**Diagnosis and Length of Stay in the Older Age Groups**

Other chronic obstructive airway disease appears from age 55 years onwards, and is responsible for average lengths of stay ranging from 4.8 days in the 55 to 59 group, to 9.4 days at age 85 plus years. Malignant disease of the respiratory system is the only cancer to appear in these lists of emergency admissions. Apart from fractured femur, the main causes of the top ten lengths of stay in the older age bands are diseases of the circulatory and respiratory systems, with cerebral infarction (stroke) having the longest average individual length of stays after fractured femur, ranging from 8.5 days at 65 to 69 years, to 11.8 days at 85 plus years. Senility only appears in the top ten diagnoses list in the age 85 years plus, where it accounts for 3.3 % of the total emergency bed days.

It is clear that the diagnoses responsible for the greatest number of emergency hospital bed days in the older age groups are the chronic diseases and accidents that would be expected. Further research and analysis is needed to understand how people come to the point of needing hospital admission, what happens to them on discharge, whether acute hospital admission is the most appropriate kind of care for them, and what care and interventions would help them to avoid hospital admission.

**Emergency Hospital Admissions, Diagnosis and District of Residence**

Review of emergency hospital admissions by diagnosis and by district of residence is important for understanding where patients are likely to be most in need of particular services. Age standardised rates for the major disease categories of cancers, circulatory disease and respiratory disease, all show men having higher emergency hospital admission rates than women, in all the Suffolk districts.

Ipswich also has the highest age standardised emergency hospital admission rate for accidents, whilst the rates for Waveney and St Edmundsbury are low, compared with Suffolk as a whole. (See figure 4.7). More detailed analysis of this data is required to gain a better understanding of why these differences occur, and what services need to be provided locally to maximise health benefits for local communities.

For cancers, age standardised rates show that residents of Ipswich, Waveney and Suffolk Coastal all have significantly higher emergency hospital admission rates than Suffolk residents as a whole, when males and females are looked at together.

For diseases of the circulatory system, Ipswich has a significantly higher rate than Suffolk, whilst the rate for Waveney it appears to be significantly lower.
For emergency admissions for respiratory disease, Ipswich again has the highest rate, but the rate for St Edmundsbury is also significantly above the Suffolk rate. Babergh has the lowest rate in Suffolk.
When death is inevitable, health and social care professionals need as far as they possibly can to enable people to have ‘a good death’ and to die in the setting of their choosing, accompanied by those close to them. It is likely that more people would like to die at home than currently do so\textsuperscript{57}. For the years 2003 to 2005, 22.5\% of people dying from cancer in England, died at home, in the East of England 24.1\%, and in Suffolk that figure was 21.7\%, or 1,224 people. Of the counties in the East of England, this was the lowest figure, the highest being Cambridgeshire with 30\% of people dying from cancer dying at home. It is not only those with cancer who may be being denied the opportunity to die at home if they wish, but those suffering from other chronic diseases. Further investigation, a needs assessment for palliative care, and work with partners is required to understand the true requirement for Suffolk residents, and how this might be met.\textsuperscript{58}

The Healthcare Commission Report

The Healthcare Commission acts as a watchdog for health services, checking on the quality and safety of services provided across the NHS. It carries an annual health check of all NHS Trusts, looking at how each trust has met the Department of Health’s core standards, is meeting targets and managing its financial resources. The Annual Performance Ratings 2005/06 for the three Suffolk acute hospital trusts rated both West Suffolk and Ipswich Hospitals as weak in their use of resources, and James Paget Hospital as good.\textsuperscript{59} Other services that the Healthcare Commission reports suggest need attention across the county are access to genito-urinary medicine (GUM) clinics, care for people who have self-harmed and those who misuse drugs, and some aspects of children’s hospital services and mental health services.\textsuperscript{60}

The Healthcare Commission also undertook a national review of diabetes services in 2006/07\textsuperscript{61}, sending out 850 questionnaires with a 56\% return rate. Key findings from this report are that only 21\% had access to a dietician, and that patients wanted written information to support the discussions they had with their doctors. The Healthcare Commission concluded; ‘Managing their own condition and being given support to do so, can have significant benefits for a person with diabetes.’ These are important messages for service commissioners and should be considered for patients with other long-term conditions. (See also Healthcare Commission survey for heart failure\textsuperscript{62})

\textsuperscript{62}Healthcare Commission 2007, Pushing the boundaries Improving services for patients with heart failure London, Healthcare Commission.
Section 5: Health Inequalities and Wellbeing

Interesting Facts . . .

- The wards with the lowest life expectancy are also the wards with the highest proportions of their over 65 year population resident in care homes.
- Across Suffolk wards as a whole, the difference between the lowest and the highest life expectancy is 12.3 years.
- Unemployment rates in Ipswich and Waveney are over three times higher than in Forest Heath.
- Ipswich Citizens Advice Bureau has received over 40% more debt enquiries per head of population than any other district.
- Migrant seasonal workers are increasingly influencing the nature of seasonal unemployment in Suffolk.
- The areas with the highest incidence of fuel poverty are the same places with the highest number of single-pensioner households.

Key Issues:

- There are signs that the poorest parts of the county are falling further behind the rest, according to gross weekly earnings figures. This is leading to increased economic inequality between different parts of the County.
- Waveney and Babergh districts are both displaying signs of longer-term economic stagnation that may have significant effects in terms of the health and social wellbeing of their inhabitants.
- Seasonal agricultural workers from EU accession states may be leading to higher levels of unemployment amongst those with low skills levels and who have traditionally relied on short-term seasonal work for income. This may also have implications for community cohesion.
- The Ipswich Citizens’ Advice Bureau has had the highest level of debt enquiries per person than any other in Suffolk.
- Fuel poverty is high in Suffolk and often occurs in rural area where there are large populations of elderly and vulnerable people.

Health inequalities are the differences in health experience between different groups of people and the general population. They are usually measured in terms of health status, morbidity or mortality and the population groups may be defined on the basis of socio-economic status, geographical location, ethnic origin, gender, age or disability. Evidence shows that, in general, people who are less well off or less socially equal or more deprived have a shorter life expectancy and more illness than the well off, more socially advantaged or less deprived. Even a relatively affluent area like Suffolk, still has pockets of health inequality.

Reducing health inequalities is a key part of any health improvement programme. Activity is usually based on tackling the underlying determinants of health including employment, skills, housing, environment; transport, social inclusion and access to services (See Section 1). This section will look at some of these issues and also describe some of those groups of people who are most vulnerable in society.
5.1 Life Expectancy as a Measure of Health Inequalities

Life expectancy at birth only tells us how long a baby born at that point in time, in that place could be expected to live, and although it is attempting to predict events far in the future, it is still a good indicator of the general health of a population. Table 5.1 below shows how life expectancy differs between men and women, and between geographical areas, and how it is gradually increasing over time. Life expectancy for men in Suffolk is at least 0.2 years better than that for men in England as a whole, and for women in Suffolk is at least 0.5 years better.

Table 5.1: Life Expectancy at Birth for Men and Women in Suffolk (by District)

<table>
<thead>
<tr>
<th>Area</th>
<th>Life Expectancy at Birth</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>76.92</td>
<td>81.14</td>
<td></td>
</tr>
<tr>
<td>East of England</td>
<td>78</td>
<td>81.8</td>
<td></td>
</tr>
<tr>
<td>Babergh</td>
<td>78.9</td>
<td>82.6</td>
<td></td>
</tr>
<tr>
<td>Forest Heath</td>
<td>78.2</td>
<td>81.6</td>
<td></td>
</tr>
<tr>
<td>Ipswich</td>
<td>77.1</td>
<td>81.6</td>
<td></td>
</tr>
<tr>
<td>Mid Suffolk</td>
<td>79.4</td>
<td>82.6</td>
<td></td>
</tr>
<tr>
<td>St Edmundsbury</td>
<td>78.1</td>
<td>81.9</td>
<td></td>
</tr>
<tr>
<td>Suffolk Coastal</td>
<td>79.2</td>
<td>82.4</td>
<td></td>
</tr>
<tr>
<td>Waveney</td>
<td>77.8</td>
<td>81.6</td>
<td></td>
</tr>
</tbody>
</table>

There is a significant difference however between wards in Suffolk, and the table below shows the lowest and highest life expectancy for persons in electoral wards in Suffolk. Due to small numbers this data needs to be treated with caution, and certainly the figure for Moreton Hall in St Edmundsbury, with its new housing estates and young population, shows the bias that result from its unrepresentative population. It should also be noted that the wards with the lowest life expectancy are also the wards with the highest proportions of their over 65 year population resident in care homes. Despite these caveats, the figures do reveal the inequalities that are to be found in an analysis of life expectancy, and therefore the significant health inequalities that exist within the County. Across Suffolk wards as a whole, the difference between the lowest and the highest is 12.3 years (excluding Moreton Hall), and an average of 8.5 years between wards within the same local authority.
Life expectancy provides here an indicator of general health inequalities across the county, and the data shows that Suffolk has 12 electoral wards amongst the 20% with the poorest health in England and Wales. By this measure, it also has 60 wards amongst the top 20% in England and Wales, and the great challenge for health and social care services is to contribute to narrowing the health gap between these different Suffolk communities, and at the same time continue to provide care and services that will improve the health and well-being of the population as a whole.

Table 5.2: Highest and Lowest Life Expectancy at Birth for all Persons, by Ward in Suffolk County Districts, 1999 To 2003 (Experimental Statistics)63

<table>
<thead>
<tr>
<th>Local Authority</th>
<th>Electoral Ward</th>
<th>Life expectancy at birth (years)</th>
<th>Life expectancy quintile (England &amp; Wales)</th>
<th>Medical &amp; Care establishments - population indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Babergh</td>
<td>Great Cornard North</td>
<td>74.6</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Nayland</td>
<td>84.7</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Forest Heath</td>
<td>St Mary's</td>
<td>77.0</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>South</td>
<td>81.4</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Ipswich</td>
<td>Bridge</td>
<td>75.2</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Bixley</td>
<td>83.9</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Mid Suffolk</td>
<td>Onehouse</td>
<td>73.5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Worlingworth</td>
<td>83.7</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>St Edmundsbury</td>
<td>Risbygate</td>
<td>75.6</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Moreton Hall</td>
<td>93.4</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Suffolk Coastal</td>
<td>Witnesham</td>
<td>76.5</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Martlesham</td>
<td>83.5</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Waveney</td>
<td>Kirkey</td>
<td>75.5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Blything</td>
<td>85.8</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

5.2 Indices of Multiple Deprivation

The Index of Multiple Deprivation 2004 is a measure of multiple deprivation at the small area level.64 It was calculated by collecting data from a range of different indicators covering seven main areas (called domains), each measuring a different aspect of deprivation. The seven domains listed below were then combined to form the overall Index of Multiple Deprivation:

- Income deprivation
- Employment deprivation
- Health deprivation and disability
- Education, skills and training deprivation
- Barriers to Housing and Services
- Living environment deprivation
- Crime

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64Office of the Deputy Prime Minister (no Communities and Local Government), 2004.

An analysis carried out by Suffolk County Council\textsuperscript{65} show that, in general, the levels of deprivation in Suffolk are low. Large areas fall within the least deprived 20\% or 40\% in the country, particularly in the centre and west of the county. There is, however, large variation in levels of deprivation recorded within Suffolk. The most deprived super output area in Suffolk, located in Kirkley, Lowestoft, ranks 413 in the country. At the other end of the scale, the least deprived super output area in Suffolk, located in Castle Hill, Bury St Edmunds, ranks 32369. All districts except Waveney had at least 1 super output area in the 10\% least deprived in the country.

Only 30 super output areas in Suffolk (or 7\%) fall within the most deprived 20\% in England. All are located in Ipswich (19) and Lowestoft (11). Only 10 of these (or 2\%) are among the most deprived 10\% in the country, and these are listed in table 5.3.

Table 5.3. Super Output Areas in Suffolk within the Most Deprived 10\% in England\textsuperscript{66}

<table>
<thead>
<tr>
<th>IMD Rank</th>
<th>District</th>
<th>Ward</th>
</tr>
</thead>
<tbody>
<tr>
<td>413</td>
<td>Waveney (Lowestoft)</td>
<td>Kirkley</td>
</tr>
<tr>
<td>1759</td>
<td>Ipswich</td>
<td>Priory Heath</td>
</tr>
<tr>
<td>1809</td>
<td>Waveney (Lowestoft)</td>
<td>Normanston</td>
</tr>
<tr>
<td>1844</td>
<td>Waveney (Lowestoft)</td>
<td>Harbour</td>
</tr>
<tr>
<td>1885</td>
<td>Ipswich</td>
<td>Gainsborough</td>
</tr>
<tr>
<td>2081</td>
<td>Ipswich</td>
<td>Alexandra</td>
</tr>
<tr>
<td>2232</td>
<td>Waveney (Lowestoft)</td>
<td>Harbour</td>
</tr>
<tr>
<td>2818</td>
<td>Ipswich</td>
<td>Gainsborough</td>
</tr>
<tr>
<td>2955</td>
<td>Waveney (Lowestoft)</td>
<td>St Margarets</td>
</tr>
<tr>
<td>3050</td>
<td>Ipswich</td>
<td>Whitton</td>
</tr>
</tbody>
</table>

Elsewhere in Suffolk, the highest levels of deprivation (i.e. super output areas in the most deprived 20\% to 40\% in the country) are located in towns scattered across the county, forming parts of Beccles, Saxmundham, Felixstowe, Hadleigh, Sudbury, Haverhill, Bury St Edmunds and Mildenhall.

The figure below shows a map of Suffolk that highlights the areas in the County where levels of multiple deprivation are highest.


\textsuperscript{66}Indices of Multiple Deprivation Report for Suffolk, Suffolk County Council 2004 (from IMD Report 2004.)
Artificially constructed estimates of lifestyle behaviour. They assign expected values for a range of behaviours by applying national survey response rates to local Census characteristics.

An individual’s state of health is affected by many different factors at different times in their life, and although we have no control over our genetic inheritance and limited control over our environment, individuals are able to some extent to adapt their lifestyles in order to make healthier choices in line with best advice about healthy living. For their part, health service and health professionals, local authorities, the private and voluntary sectors, need to ensure that information and services to promote healthy living are accessible and acceptable to all members of the community who could benefit.

5.3 Health Behaviours

There is limited information about the lifestyle behaviours of Suffolk residents. The information available is largely drawn from the relatively small local samples included in national surveys. The following information provides synthetic estimates derived from the Health Survey for England, and takes no account of any factors, (e.g. local initiatives designed to reduce binge drinking), which may have an impact on the true local prevalence. They do however give some indication of areas where health promotion messages and services should be targeted, and it can be seen that the areas with the unhealthiest lifestyles, are those that are deprived on other measures. Harbour ward in Waveney, Gainsborough in Ipswich and Stowmarket South appearing at the bottom of

5.3.1 Healthy Lifestyles

Figure 5.1: Map Showing Areas of Overall Multiple Deprivation (red) in Suffolk
their respective local authorities on more than one of the four measures (smoking, obesity, binge drinking and fruit and vegetable consumption).

The following charts show the estimated occurrence of different lifestyle behaviours in local authorities in Suffolk\(^6^8\). These estimates have been based on very small local samples used for the Health Survey for England and have to be treated with caution, but at present this is the best local data available. The high/low lines represent the maximum and minimum estimated ward prevalence values in that local authority.

### Smoking

Smoking is a major cause of ill health and premature death in the UK, particularly respiratory illness, cancer and coronary heart disease, and affects not only the smoker but also those around him or her\(^6^9\). The consequences of smoking have been known for a long time, yet young people continue to take up smoking, and many older smokers find it an addiction that is hard to overcome. The Suffolk wards with the highest estimates of percentage of the population smoking, were Harbour in Waveney, Haverhill South, and Gainsborough in Ipswich, whilst the lowest percentage were Lower Brett in Babergh and Rushmere St Andrew in Suffolk Coastal.

**Figure 5.2: Synthetic Estimate of Smoking Prevalence for Wards in Suffolk**

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**Obesity**

It has been suggested that obesity is now reaching epidemic proportions in the UK. Obesity has been shown to increase the risk of heart disease, cancer and diabetes, as well as being a contributory factor to many other illnesses. Both poor diet and lack of physical activity contribute to obesity, and is now a matter of particular concern for the future health of children and young people. There appear to be high inequalities within the County, with synthetic ward estimates showing even the least obese wards in Waveney to have a higher estimated percentage of obesity than the average estimates for the East of England. Amongst children however, a recent study in Suffolk\(^7\) showed that approximately 8.4% of children in Suffolk are obese at age 5 years and 18% at age 11 years, and that this was not associated with any particular area of the county, leading them to conclude that interventions should be universally targeted. (See Section 6, Children and Young People Services - “Being Healthy”).

**Binge Drinking**

Excessive alcohol consumption is not only a major cause of ill health and premature death, but is also a cause of accidents and a factor in many criminal offences and other social problems. In Suffolk, estimates suggest that binge drinking is most prevalent in the most deprived wards in Ipswich and St Edmundsbury and also in wards with a high proportion of younger residents (Pinewood in Babergh and Moreton Hall in St Edmundsbury). See also Section 5.7.10 on “Drugs and Alcohol Misuse.”

**Fruit and Vegetable Consumption**

The importance of a diet rich in fruit and vegetables and its contribution to well being and the prevention of some diseases has been well understood and widely promoted for sometime. However, in Suffolk, wards such as Harbour and Kirkley in Lowestoft, St Olaves, Whitehouse and Gainsborough in Ipswich and Haverhill South where the synthetic ward estimates suggest the problem is most serious. Research suggests a number of causes including cost, lack of access to fresh food, lack of cooking skills, but shows that this is a complicated problem, which needs to be fully investigated so that appropriate interventions can be put in place locally.

**Physical Activity**

Sport England and the Eastern Region Public Health Observatory have recently published the results of the first survey of physical activity in the East of England\(^7\). Over 7000 Suffolk residents were interviewed to ascertain how active they were in their day-to-day lives and to what extent they volunteered their time to their communities. The survey was a first attempt to monitor the effects of efforts to increase participation levels in sport, improve access, and increase the health and wellbeing of the community, in line with the priorities of Suffolk Sport, the County Sports Partnership. The results

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\(^7\)Sport England and Eastern Region Public Health Observatory July 2007 Activity Profiles Suffolk Local Authorities.
cover a wide-range of indicators, including information about participation in walking, cycling, sports, club membership and volunteering.

Working with Sport England, Suffolk Sport has been involved in collating, interpreting and disseminating the results for Suffolk and district areas across the county. The results for the main participation indicator, (3 occasions of 30 minutes moderate intensity exercise each week), are shown in Figure 5.3. The figure shows that residents in Ipswich and Waveney are the least active in Suffolk, with only 17% participating in 30 minutes exercise three times a week, contrasting with 24% in Forest Heath and 22% in Suffolk Coastal. 57% of those in Waveney and 54% in Ipswich do no exercise at all per week (zero occasions of 30 minutes moderate intensity exercise). These results are below the national average and also compare unfavourably with the regional average.

An interesting finding was that respondents with a car were significantly more likely to participate in three thirty-minute sessions of exercise a week than those without a car. This may reflect the fact that those without cars are unable to access swimming pools, football pitches, gyms, start of walks, etc. so easily.

The survey also found that participation is negatively associated with age and limiting illness/disability, and positively associated with economic status, which may explain the low levels of physical activity in parts of Ipswich and Waveney, which are often the places with the highest scores for some of these indicators. They are also often the places with higher levels of mental and physical health problems. However, comparisons with nearest neighbour authorities on the Index of Multiple Deprivation (IMD) demonstrate that deprivation factors alone cannot always explain the lower results for the Ipswich and Waveney areas.

Figure 5.3: Percentage of the Population Taking Part in 3x30 Minutes Exercise per Week
A recent study has shown that there is robust evidence for the positive impact of physical activity on mental health: it can improve the quality of life for people with mental health problems or be used as a treatment or therapy, and it can also prevent the onset of mental health. Physical activity can also improve the mental wellbeing of the general population.72

Volunteering

The role of communities, groups, and individuals in giving their time voluntarily to a cause can have strong benefits in terms of health and wellbeing status for both the volunteers and those involved in the cause they are volunteering for. This is not only because volunteering may involve some physical activity and therefore help people to stay physically healthy, but also because it provides an opportunity for volunteers to meet new people and to make a contribution to the community, increasing feelings of empowerment, fulfilment and overall wellbeing. Participation and involvement in the community also appears to have an important effect on mental health.73

Individuals may either volunteer their time formally (i.e. for a particular organisation) or informally. The nature of volunteering means that these two are often difficult to separate out from one another, a fact reflected in some of the findings below. Whilst the Local Public Sector Agreement (LPSA) Target 12 focuses on formal volunteering, the Active People survey results will capture elements of both, due to the random sample used in the survey.

Research conducted in 200674 to ascertain levels of formal volunteering in Suffolk show a heavy bias towards women and those in the 50 to 64 age group volunteering formally for their communities, with Lowestoft and Felixstowe having the highest overall rates. 20% of the total population (approximately 140,000 people) formally volunteer in some way. Those in Sudbury had the lowest level of formal volunteering (8%), but the highest level of informal volunteering (23%)

Another source of information on volunteering comes from the Active People survey discussed in the previous section. The Active People Survey asked respondents how much time a week they volunteered (both formally and informally) to support sport. This included organising or helping to run an event, campaigning/raising money, providing transport or driving/ taking part in a sponsored event/ coaching, tuition, mentoring etc. Suffolk's results in this survey put volunteering levels slightly above the average for the East of England and national levels:

- Men are twice as likely as women to volunteer 1 hour a week of their time (6.8 against 3.2%), contradicting the findings of the research on formal volunteering carried out in 2006. This suggests that whilst women volunteer more overall in Suffolk, when it comes to physical activity and sports, men are more inclined to give their time.
- Younger people are more likely to volunteer than older people when it comes to sports.
- Those whose ethnicity is white are more likely to volunteer than those whose ethnicity is non-white (5% against 3.3%).

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73 See footnote 57.
74 LPSA target 12 baseline study (2006) Suffolk Development Agency.
Those in higher socio-economic groups are more likely to volunteer. Those with a limiting disability are less likely to volunteer than those without. Those with a car are more likely to volunteer.

The Active People Survey showed that all the district and borough areas in Suffolk have volunteering levels just above the national average (4.7%) and at least as high as the regional average (4.9%), with the exception of Ipswich, which has volunteering levels far below the regional and national averages, with only 3.7% of respondents participating in at least 1 hour per week to support sport.

The “Suffolk At Home” libraries service found that there are higher levels of volunteering in the urban areas, particularly Ipswich, Bury St. Edmunds and Lowestoft. There are also high levels of inequality in volunteering levels between areas – Aldeburgh library for instance has more volunteers than Felixstowe and nearly as many as Ipswich, despite its small size. This may reflect very local initiatives aimed at promoting volunteering levels. Other libraries have very low levels of volunteering, with Elmswell, Great Cornard, Ixworth and Stradbroke recording zero volunteers. Given the small numbers associated with many of the other, often more rural libraries, it is difficult to analyse what this may mean.

5.3.2 Uptake of Prevention Services and Screening

The National Health Service offers a number of health screening and preventative services for different sections of the population. People are encouraged to make use of these services through national and local campaigns and by their own health care professionals. However, people may choose not to be screened or vaccinated or have their children immunised for many different reasons and as providers of and commissioners for these services, we need to understand what these barriers or difficulties may be.

Childhood Immunisation and Vaccination Programmes

Vaccination and immunisation programmes for both children and adults aim not only to protect the individual but also to protect the community in which they live by so called ‘herd immunity’. This means that a given percentage of the population needs to have been immunised against a specific disease in order to prevent its spread and an outbreak, for example it is estimated that 95% of all children need to be vaccinated against measles to confer herd immunity.

The reasons parents choose not to have their children immunised are varied and personal, but the press reports of the controversy over the measles, mumps and rubella triple vaccine (MMR) had an undoubted effect on the uptake nationally and in Suffolk. This has recovered, but still needs to be improved. Parents may have difficulty getting to a GP surgery or clinic, or they may simply not understand the significance or importance of immunisation for their children, issues which commissioners and health professionals have to consider.

Childhood immunisation take up rates for the former Suffolk primary care trusts (Ipswich, Suffolk Coastal, Central Suffolk, Waveney and Suffolk West Primary Care Trusts) have been very similar over the years 2002 to 2006, except that rates for vaccinations at the time of 2nd birthday have been slightly lower for Ipswich Primary
Care Trust. All the rates have been similar to those for England as a whole, with more than 90% of the eligible children vaccinated. The exception is the take up rates for the combined measles, mumps and rubella vaccine, which were around 85% across Suffolk during that time (84.1% in England 2005/06), although they have begun to increase slightly in the later years. This demonstrates the power of the media, as well as the fact that professional health information needs to be thoroughly communicated across all communities, and needs to be effectively tailored for differing levels of understanding.

### Influenza (‘Flu) and Pneumococcal Vaccination Programme

The elderly and those with long term health conditions such as chronic respiratory disease are particularly vulnerable to influenza (flu) and to the pneumococcal bacteria, which can cause pneumonia. This can result in hospital admission, be debilitating and potentially fatal. For the last few years, every autumn each primary care trust has run a ‘flu vaccination campaign for all their residents over the age of 65 years. The vaccines are also offered to other groups considered to be at risk. Vaccinations are given at GP surgeries, and some practices take the opportunity to offer wider healthcare information and support to those attending.

For the winter 2006/07 there was variation in the ‘flu vaccination take up rates in those aged over 65 years between the primary care trust areas, as shown in the table below. There was considerable variation between the uptake rates of the different practices within each primary care trust, ranging from 62.1% in Eye to 85.8% in Ipswich in 2006/07.

#### Table 5.4: Uptake of Flu Vaccine for the Over-65s in Suffolk

<table>
<thead>
<tr>
<th>Primary Care Trust</th>
<th>Total % Uptake</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suffolk PCT</td>
<td>74.3%</td>
</tr>
<tr>
<td>Great Yarmouth and Waveney PCT</td>
<td>74%</td>
</tr>
<tr>
<td>England</td>
<td>73.9%</td>
</tr>
</tbody>
</table>

### Dental Care

Poor oral health is not only painful, but can be a contributory factor in a number of diseases and a cause of general ill health at any age. We have some information about the dental health of children and young people in Suffolk, but no dental survey of adults in the general population. A separate dental care needs assessment is currently being undertaken for Suffolk, and should be used to complement this document.

We do not have data to show us trends in dental health in children across the County, because of the constant health boundary changes between surveys, but the latest information for 5 year olds shows us that 27.4% of 5 year olds in Suffolk PCT had decayed, missing, or filled teeth. This survey also showed that for those children who...
have dental decay, the mean rate of decayed, missing or filled teeth is 3.16, making it a serious health problem.

**Table 5.5: Percentage of Children with Decayed, Missing or Filled Teeth**

<table>
<thead>
<tr>
<th>Dental Caries Experience of 5-year-old Children in Great Britain 2005 / 2006</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surveys co-ordinated by the British Association for the Study of Community Dentistry</td>
<td></td>
</tr>
<tr>
<td>England</td>
<td>38.0%</td>
</tr>
<tr>
<td>East of England</td>
<td>32.1%</td>
</tr>
<tr>
<td>Great Yarmouth and Waveney PCT</td>
<td>39.1%</td>
</tr>
<tr>
<td>Suffolk PCT</td>
<td>27.4%</td>
</tr>
</tbody>
</table>

A similar survey of 14 year olds carried out in 2002/03 showed that the mean number of decayed, missing or filled permanent teeth in this group was:

- England 1.4
- East of England 1.09
- Suffolk PCTs 1.28
- Norfolk PCTs 1.07

These children are at increased risk of further related health problems in their adult life.

**Screening**

**Cervical Screening**

Cervical screening detects abnormalities that could go on to develop into cancer if left untreated. Cervical screening began in the UK during the mid 1960’s. The NHS cervical screening programme was set up in 1988\(^7\) and in the ten years to 1997, the incidence of cervical cancer in England and Wales fell by 42%. It is now estimated that cervical screening saves approximately 4,500 lives in England annually. However, women in Suffolk are still developing and dying from a disease, which if detected early enough can be prevented, and is treatable if found at an early enough stage. Between 2002 and 2004, 40 women in Suffolk were diagnosed with cervical cancer. However local trends show that cervical screening coverage has declined slightly. It is important to understand the reasons that prevent women from coming forward for screening.

\(^7\)NHS Cervical Screening Programme
Breast Screening

Although the death rate from breast cancer has been falling over recent years, it was the main cause of death for 148 women in Suffolk in 2005, 86 of whom were under the age of 75. The latest figures show that the standardised mortality ratio (SMR) for breast cancer for Suffolk for the years 2003-2005 was the same as for England. There was variability between the Suffolk local districts, with Babergh, Suffolk Coastal and St Edmundsbury having the higher rates (although none of these figures was statistically significant). The NHS Breast Screening programme was introduced in 1988 and it is estimated that it has resulted in a 25% reduction in mortality from breast cancer. The chart below shows the trend in breast screening coverage rate for the Suffolk PCTs between 2002 and 2005, showing a steady increase in those areas where the rate was relatively low and leading to a convergence of the poorest performers with the best. By 2005 the coverage rate for eligible women in England was 75%, in the East of England was 78.7% and for all the Suffolk PCTs was above 81%. Although this is encouraging for Suffolk, it means that almost one fifth of the county’s eligible women are not coming forward for screening, and the reasons for that need to be understood.

The aims of the maternity services are to promote and maintain health for mothers and babies and their families, as well as providing acute and emergency services when they are needed. Successful outcomes for the service rest primarily on good screening and risk detection, and also on the actions taken and care provided by the service itself. Whilst much care may be provided in the community, this has to be in the context of an integrated service with excellent specialist obstetric and paediatric care immediately available and accessible. Analysis of hospital admissions shows that obstetric care and emergencies account for a significant proportion of all admissions.

In 2005, 7,493 babies were born in Suffolk, including about 300 at the US military hospital and the county’s maternity units report that numbers are rising. 427 of these babies were born at home, and the Government’s latest maternity care policy ‘Maternity Matters’ indicates that the proportion of home birth should increase, which will place increased demands on community services. Maternity statistics also reveal Suffolk has a statistically significant lower rate of infant mortality compared with England.

Although the numbers of babies born of low birthweight (less than 2.5kgs) in Suffolk in 2005 is a lower rate than England as a whole (6.9 and 7.9 per 1,000 live and stillbirths) this represents 519 babies in Suffolk who may have varying special health, educational and social needs, throughout their lives.
5.4 Economic Wellbeing and Education

Economic factors and education are key in determining the health and social wellbeing status of communities, individuals and groups in Suffolk. As a county with a below average level of earnings and low productivity, Suffolk also has high levels of inequality between geographical areas, often with some of the most affluent communities living adjacent to some of the poorest.

A recent study shows that education has significant bearing upon employment and social inclusion, both of which impact on mental and physical health. People with no or low level qualifications and the unemployed are at a higher risk of having mental health problems.\(^78\)

This section explores these and other factors within the context of the overall picture presented in this document. Much of the information contained within this section is drawn from a report entitled ‘The State of Suffolk: An Economic, Social and Environmental Audit of Suffolk’ produced by the Local Futures Group in October 2006.

5.4.1 Earnings and Productivity

Compared to other counties, Suffolk has a relatively small economy with below average levels of productivity. The districts with the largest economies within Suffolk are Ipswich and St. Edmundsbury. Those with the smallest are Forest Heath and Babergh. The productivity of all the Suffolk districts is below the national average\(^79\).

Average gross weekly earnings were £349.40 per week (£18,238 per year) in Suffolk in 2005, compared to £413 per week (£21,559 per year) for the East of England and £424 per week (£22,133 per year)\(^80\) for Great Britain. This is relatively low and makes Suffolk one of the lowest paying sub regions in Britain. Within this county-wide figure there is some variation however; Suffolk Coastal is the district with the highest earnings in the county, but its figures still fall short of national and regional figures. At the other end of the scale, Waveney and Babergh rank in the bottom tenth of authorities for average gross weekly earnings.

Despite the low base levels of earnings in Suffolk, growth in earnings was strong at 23.2% between 1999 and 2005, compared with 24% nationally. There is however some signs that the areas with the lowest levels of income are falling further behind the rest, perhaps indicating a failure to capitalise on the strong overall economic picture nationally. Whilst Forest Heath, Suffolk Coastal, St. Edmundsbury and Ipswich have all recorded earnings growth in excess of 20% since 1999, Babergh and Waveney (the districts with the lowest weekly income) recorded only 7.7% and 17.7% respectively. Attention may need to be given to more pro-actively engaging with this situation in order to prevent a further widening in earning inequalities in Suffolk.


\(^{79}\)The Local Futures Group, ‘The State of Suffolk; An Economic, Social and Environmental Audit of Suffolk’ October 2006. The Local Futures Group is a private sector research consultancy that looks at social and environmental change in local areas from a geographical perspective.

\(^{80}\)Based on one year being 52.2 weeks in length.
The State of Suffolk Report notes that in rich countries a critical factor to economic performance is the growth of the ‘knowledge’ economy across and within all sectors. This is marked by increasing levels of innovation, technology, creativity and entrepreneurship and is driven by a more skilled and educated workforce.\(^{81}\)

As with the findings on earnings and productivity, Suffolk has a lower than average proportion of its jobs in knowledge driven sectors. There are however encouraging signs that the county is catching up with others in this respect, with all districts except Babergh and Waveney displaying very high growth in knowledge driven sectors between 1998 and 2004. Waveney recorded only a small increase of 4.12% over the same period and Babergh actually declined by over 4%. If the ability to attract skilled and creative people to an area is considered to be a key determinant of future growth and prospects, then Babergh and Waveney may be at risk of entering a period of economic stagnation unless efforts are made to change this trend.

**5.4.2 Economic Structure and Enterprise**

Despite poor overall economic and skills performance, Suffolk has a relatively high level of employment at 77.2% compared to 74.3% nationally and 76.9% regionally (2006).\(^{82}\) Within Suffolk, Ipswich has the highest employment rate at 80.9% and Mid Suffolk the lowest at 74%.

Recent analysis\(^{83}\) highlights the potentially significant role new migrant workers may be having on the structure of seasonal employment levels in the county. It notes that the drop in unemployment that usually occurs between February and October, as seasonal employment increases, failed to occur on the same level as previous years. One possibility is that this is caused by the increase in the number of seasonal jobs taken up by migrant workers from the new Eastern European EU states, many of whom work in factories, as care assistants, on farms or in food processing industries. This may have implications for community cohesion, particularly amongst those with low skill levels in rural areas and who have traditionally relied on short-term employment opportunities that are now being taken by new arrivals.

**5.4.3 Employment and the Labour Market**

Unemployment is associated with social exclusion, which has a number of adverse effects including reduced psychological well being, and a greater incidence of self harm, depression and anxiety.\(^{84}\)

With an unemployment claimant rate (Job Seekers Allowance) of 1.6%, the Region is considered to now have virtually full employment (October 2007). Suffolk has a similar rate (1.7%), but within the county there is considerable variation. The rate for Ipswich is 3.0% with Waveney not far behind at 2.9%, whereas the claimant rate for Suffolk Coastal is the lowest at 0.9%.\(^{85}\)

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\(^{81}\)The Local Futures Group, ‘The State of Suffolk; An Economic, Social and Environmental Audit of Suffolk’ October 2006.

\(^{82}\)NOMIS, 2007.


\(^{84}\)“Mental Health Vision,” Suffolk County Council, 2007.

\(^{85}\)ONS claimant count in NOMIS, 2007.
The town with the worst unemployment claimant rate is Lowestoft at 4.0%. Rates for individual wards vary considerably, with 3 wards in Lowestoft, 7 wards in Ipswich and the relatively rural wards of Southwold and Reydon having rates over double the County average. A further 35 wards have rates greater than the County average and of these only one is wholly rural. The unemployment claimant count is higher amongst men (2.3%) than in women (1.1%).

### 5.4.5 Benefits

The table below shows the type of benefits claimed by people of working age in Suffolk in May 2007. The uptake of benefits is lower than the national average for incapacity benefit – 5% compared to 7.2% of working aged adults in Great Britain. There is also a lower uptake of lone parents benefit in Suffolk compared to the national average (1.5% compared to 2.1%).

**Table 5.6 Working-age client group - key benefit claimants (May 2007)**

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Suffolk (numbers)</th>
<th>Suffolk (%)</th>
<th>Eastern (%)</th>
<th>Great Britain (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total claimants</td>
<td>45,510</td>
<td>10.9</td>
<td>10.9</td>
<td>14.2</td>
</tr>
<tr>
<td>Job seekers</td>
<td>7,530</td>
<td>1.8</td>
<td>1.8</td>
<td>2.3</td>
</tr>
<tr>
<td>Incapacity benefits</td>
<td>20,800</td>
<td>5.0</td>
<td>5.1</td>
<td>7.2</td>
</tr>
<tr>
<td>Lone parents</td>
<td>6,080</td>
<td>1.5</td>
<td>1.7</td>
<td>2.1</td>
</tr>
<tr>
<td>Carers</td>
<td>4,400</td>
<td>1.1</td>
<td>0.9</td>
<td>1.0</td>
</tr>
<tr>
<td>Others on income related benefits</td>
<td>1,770</td>
<td>0.4</td>
<td>0.4</td>
<td>0.5</td>
</tr>
<tr>
<td>Disabled</td>
<td>3,770</td>
<td>0.9</td>
<td>0.8</td>
<td>0.9</td>
</tr>
<tr>
<td>Bereaved</td>
<td>1,160</td>
<td>0.3</td>
<td>0.3</td>
<td>0.3</td>
</tr>
</tbody>
</table>

*Source: DWP benefit claimants - working age client group as a proportion of resident working age people, May 2007*

### 5.4.6 Skills and Qualifications

The strength of the knowledge economy is linked to the education, skills and knowledge of the workforce. Using an index that gave greater weighting to higher NVQ levels, the State of Suffolk Report shows Suffolk as having a lower score than either the East of England or the United Kingdom averages.

Forest Heath has one of the poorest skills profiles in the UK, ranking 397 out of 408 local authorities nationally[^1], with Waveney and Ipswich following someway behind. The proportion of those qualified to NVQ level 1 or below in Suffolk is also above the regional (33.8%) and national (33.3%) averages at 35.2%, with Forest Heath the least educated at 48.2% and Ipswich and Waveney following behind at around 37.5%. As mentioned above, this may be a long-term constraint on economic performance and vibrancy for these areas.

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[^1]: Greater clarity is required to understand whether the US military & associates – who constitute about 1/5th of Forest Heath’s population – are included in these figures.
The proportion of working age people with degrees in Suffolk is 23.2% which is lower than both the figures for the East of England (24.8%) and for the United Kingdom (26.4%).

5.4.7 Adult Community Learning

Adult learning schemes aim to develop the skills and qualifications base of those aged over 18 years old in Suffolk. Courses vary from vocational ones such as basic mathematics and literacy to information technology skills and ‘softer’ courses of a less vocational nature (“evening classes”) such as card making.

Suffolk County Council delivered courses to 16,814 people in 2005/2006, 10.3% of whom considered themselves to have a learning difficulty and/or a disability and/or a health problem of some kind. There is extensive literature on the mental health benefits of learning, which may include both personal growth and development and the value of participation in learning opportunities.88

More women attend the courses than men (See Figure 5.6), for a number of reasons: the subject matter, the need for the qualification, women’s greater need or inclination to attend this sort of social activity, their ability to fit further education around their lifestyle etc.

Figure 5.6: Delivery of Adult Learning Courses by Gender (%)

Suffolk County Council adult learning courses attract a greater proportion of people from black and ethnic minority groups (BME) than live in the county, with 5.9% of adult learners belonging to a BME group as compared to 2.8% for the Suffolk population as a whole.

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87Information supplied by Wing Yu Ho from Suffolk County Council Adult and Community Learning.
88Suffolk County Council’s Mental Health Vision 2007.
The results above suggest that Suffolk’s adult learning programme is effectively targeting these client groups.

Within the context of the rising number of people living in Suffolk for whom English is not a first language, the Adult Community Learning service offers English for Speakers of Other Languages (ESOL) courses. 1,010 people enrolled on an “English for Speakers of Other Languages” course in 2005/06.

5.4.8 Fuel Poverty

The Fuel Poverty Indicator is a model of fuel poverty based on the 2003 English House Condition Survey (EHCS) and 2001 Census. The EHCS was used to predict the risk of fuel poverty for different household types, the results were then applied to the 2001 Census to predict the level of fuel poverty for all Lower Super Output Areas in England.

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57 Many thanks to the Centre for Sustainable Energy at: http://ccgi.gstarss.plus.com/newfpi.php?mopt=1&pid=welcome.

89 Lower Super Output Area are geographical units used in the Census, each of which contain approximately the same number of households - about 400.

Broadly speaking, a household is defined to be in fuel poverty if it spends more than 10% of its annual income on heating. Figure 5.8 shows that the prevalence of fuel poverty in Suffolk is high, and that the areas with the highest apparent levels of fuel poverty are often also the areas with the highest numbers of single-pensioner households and the largest older populations, particularly in the Suffolk Coastal and Waveney areas. They are also the areas with the worst housing (according to the Indoors Housing Domain of the Index of Multiple Deprivation), which likely to be due to an ageing housing stock that cannot be readily improved (where a building is listed or in a Conservation Area), so residents often can’t heat and can’t insulate to prevent heat loss. The other areas that the map shows with high fuel poverty are in Pakenham, parts of Mid-Suffolk and the area north of Haverhill.

5.4.9 Debt

The National Health Service offers a number of health screening and preventative services for different sections of the population. People are encouraged to make use of these services through national and local campaigns and by their own health care professionals. However, people may choose not to be screened or vaccinated or have their children immunised for many different reasons and as providers of and commissioners for these services, we need to understand what these barriers or difficulties may be.

Footnote: Suffolk Bureau Statistics.

The Joint Strategic Needs Assessment for Suffolk 2008–2011 71
Table 5.7: Number of Debt Enquiries by District Area 2005/06

<table>
<thead>
<tr>
<th>District</th>
<th>No. of enquiries</th>
<th>Enquiries per capita</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ipswich</td>
<td>16,176</td>
<td>0.13</td>
</tr>
<tr>
<td>St. Edmundsbury</td>
<td>8,555</td>
<td>0.09</td>
</tr>
<tr>
<td>Waveney</td>
<td>8,409</td>
<td>0.07</td>
</tr>
<tr>
<td>Mid-Suffolk</td>
<td>8,300</td>
<td>0.09</td>
</tr>
<tr>
<td>Suffolk Coastal</td>
<td>4,718</td>
<td>0.04</td>
</tr>
<tr>
<td>Forest Heath</td>
<td>2,671</td>
<td>0.05</td>
</tr>
<tr>
<td>Babergh</td>
<td>1,218</td>
<td>0.01</td>
</tr>
</tbody>
</table>

5.5 Housing

Housing, its availability, cost and quality is an important element in determining the overall health and well-being of individuals and populations. This section looks at the private sector housing market and affordability, before examining barriers to housing.

5.5.1 Housing Supply and Growth

The population increases are linked with the proposed housing provision in the East of England Plan that will be subject to review and is likely to alter in line with Government guidance. It envisages a significant and prolonged programme of house building in sustainable locations i.e. near employment, services and facilities and on major transport routes that meets local need and copes with people moving here. However the proposals are expressed in terms of housing units rather then by tenure, price or suitability. The problem could be compounded by a larger than anticipated increase in second-home ownership in the County; particularly in the Suffolk coastal area where a large proportion of properties are currently classed as second homes.

There are several groups in the County who have specific and often unmet needs in relation to housing in Suffolk: first time buyers, rural locals, new arrivals and young families in particular.

The Draft East of England Plan identified 478,000 more homes to be built in the Eastern Region by 2021, of which 58,600 (2,930 per year) were scheduled to be in Suffolk. This will have an impact on health and social care demand levels and will need to be factored into capacity plans and strategic plans.

The Government, however, has published its proposed changes to the Draft Plan, with a proposed increase in the requirement for more homes from 478,000 to 508,000 during this period. For Suffolk, this means an increase from 58,600 to 61,700 homes. The majority of the growth is earmarked for the Ipswich area (20,000 homes) and St Edmundsbury (10,000 homes). Even if all these homes were to be built, they will constitute a small proportion of all the homes in Suffolk.

http://www.laria.gov.uk/content/features/78/feat7.htm.
The figures above reflect the economic buoyancy of much of the county apart from Waveney. However, the Draft East of England Plan identifies some real challenges to securing these levels of housing supply, in particular the lack of adequate infrastructure, both physical, such as roads, and social, such as education and health facilities.

5.5.2 Affordable Housing

One of the main ways of looking at the affordability of housing is to look at how the average price of a house in an area relates to how much people earn. This is known as the Earnings Multiplier, and the bigger it is the less affordable housing in an area is to the people who live there. For example, an Earning Multiplier of 7 means that the average house costs 7 times the average income, and would be more affordable than a place with a Multiplier of 9.

Babergh and Mid-Suffolk saw the biggest increases in their earnings multipliers for all houses between 2004 and 2007, from 7.17 and 7.77 to 9.33 and 9.11 respectively. The places with the lowest multipliers (the most affordable) in 2007 were Ipswich, which actually saw an increase in affordability, with the Multiplier falling from 5.76 in 2004 to 5.68 in 2007, and Waveney with a slight increase to 7.43 in 2007. See table 5.8.

Table 5.8: Affordability of All Housing by District 2007 (Least Affordable at the Top)

<table>
<thead>
<tr>
<th>District</th>
<th>Earnings Multiplier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Babergh</td>
<td>9.33</td>
</tr>
<tr>
<td>Mid Suffolk</td>
<td>9.11</td>
</tr>
<tr>
<td>St. Edmundsbury</td>
<td>8.34</td>
</tr>
<tr>
<td>Suffolk Coastal</td>
<td>7.96</td>
</tr>
<tr>
<td>Forest Heath</td>
<td>7.52</td>
</tr>
<tr>
<td>Waveney</td>
<td>7.43</td>
</tr>
<tr>
<td>Ipswich</td>
<td>5.68</td>
</tr>
</tbody>
</table>

For terraced houses, which are often entry-level homes for first-time buyers, the pattern of affordability was similar, although St Edmundsbury emerged as the least affordable area, with an earnings multiplier of 6.63. Table 5.9 below shows the affordability of terraced housing by district, starting with the least affordable. The right hand column shows the multiplier for terraced housing with average earnings.

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Information on affordable housing and earnings multipliers from Her Majesty’s Land Registry.
Table 5.9: Affordability of Terraced Housing by District 2007

<table>
<thead>
<tr>
<th>District</th>
<th>Earnings multiplier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Babergh</td>
<td>6.54</td>
</tr>
<tr>
<td>Mid Suffolk</td>
<td>6.14</td>
</tr>
<tr>
<td>St. Edmundsbury</td>
<td>6.63</td>
</tr>
<tr>
<td>Suffolk Coastal</td>
<td>6.28</td>
</tr>
<tr>
<td>Forest Heath</td>
<td>5.81</td>
</tr>
<tr>
<td>Waveney</td>
<td>5.7</td>
</tr>
<tr>
<td>Ipswich</td>
<td>4.86</td>
</tr>
</tbody>
</table>

### 5.5.3 Housing Tenure

Table 5.10 below shows that the majority of residents in Suffolk (72%) are owner-occupiers, higher than the national average (69%) but slightly lower than the East of England average (73%). However, the proportion of social rented housing (from local authority, housing association or registered social landlord) is lower than the national average.

Table 5.10: Household Tenure In Suffolk Comparison With Other Areas (2001 Census)

<table>
<thead>
<tr>
<th></th>
<th>Suffolk</th>
<th>East of England</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>% who are owner occupiers</td>
<td>72%</td>
<td>73%</td>
<td>69%</td>
</tr>
<tr>
<td>% social rented</td>
<td>15%</td>
<td>16%</td>
<td>19%</td>
</tr>
<tr>
<td>% private rented</td>
<td>13%</td>
<td>11%</td>
<td>12%</td>
</tr>
</tbody>
</table>

Table 5.11 below shows that there is considerable inequality in household tenure by ethnic group. Home ownership is far higher amongst those whose ethnicity is white, at 72% of the population against 40% of the Black population and figures around 50% for other ethnic groups. The proportion of those in social rented housing is highest amongst those of black, Asian and mixed-race ethnicity, who are also, along with the Chinese group, the groups most likely to privately rent accommodation. It is important to remember that the black and minority ethnic group in Suffolk comprises a relatively small 2.8% of the population.

Table 5.11: Household Tenure by Ethnic Group Census 2001

<table>
<thead>
<tr>
<th></th>
<th>All people</th>
<th>White</th>
<th>Mixed</th>
<th>Asian</th>
<th>Black</th>
<th>Chinese and other</th>
</tr>
</thead>
<tbody>
<tr>
<td>% who are owner occupiers</td>
<td>72%</td>
<td>76%</td>
<td>52%</td>
<td>59%</td>
<td>49%</td>
<td>65%</td>
</tr>
<tr>
<td>% social rented</td>
<td>15%</td>
<td>15%</td>
<td>28%</td>
<td>19%</td>
<td>27%</td>
<td>9%</td>
</tr>
<tr>
<td>% private rented</td>
<td>13%</td>
<td>9%</td>
<td>20%</td>
<td>22%</td>
<td>24%</td>
<td>26%</td>
</tr>
</tbody>
</table>
Given the fact that community clusters of non-white residents tend to be in the urban centres it is likely that the table above hides the fact that there are areas in the County, and especially in more deprived urban areas, where levels of social housing occupancy are far higher amongst certain ethnic groups than the table above suggests.

### 5.5.4 Barriers to Housing (Indices of Multiple Deprivation)

As discussed in Section 5.2, one of the seven domains of the Indices of Multiple Deprivation 2004 deals with barriers to housing. These results incorporate information on household overcrowding, affordability of housing and the percentage of households who have made applications for assistance under the homeless provisions of housing legislation. The highest levels of deprivation in this case are almost all in rural areas, where barriers to housing appear to be a major form of deprivation. This is the case despite the fact that outwardly rural Suffolk often appears to be far less deprived than many of the urban areas. There are often very high levels of inequality between areas very close geographically to one another, for instance, St. Margaret’s in Ipswich is in the bottom 20% in England but is located next to a Super Output Area that is amongst the best in the Country.

Areas with high barriers to housing are often also located far away from services such as shops and post offices and consequently are likely to be associated with issues of rural isolation and deprivation. See section six for an analysis of access to key services.

### 5.6 Crime

The role of crime, particularly anti-social behavior and criminal damage in affecting the quality of life of residents cannot be underestimated. Research has shown a positive relationship between levels of multiple deprivation and the level of criminal damage and anti-social behavior in an area. The two tend to occur in similar areas and so only the map for anti-social behavior is shown (see Figure 5.12). Areas with higher levels of anti-social behaviour include Leiston, Saxmundham, Woodbridge, Needham Market, Hadleigh, Sudbury, Haferhill, Newmarket and Mildenhall. Also Ipswich, Lowestoft and Bury St. Edmunds.96

The following table shows the wards that contain super-output areas in the worst 10% for anti-social behaviour. These are often the same places as those that have lower scores across a range of lifestyle, social, and economic indicators (see all other sub sections in Section 5).

<table>
<thead>
<tr>
<th>Town/City</th>
<th>3.1. Ward</th>
<th>3.2. Offence Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ipswich</td>
<td>Gipping</td>
<td>91</td>
</tr>
<tr>
<td></td>
<td>Alexandra</td>
<td>358</td>
</tr>
<tr>
<td></td>
<td>Bridge</td>
<td>125</td>
</tr>
<tr>
<td></td>
<td>Priory Heath</td>
<td>118</td>
</tr>
<tr>
<td>Lowestoft</td>
<td>Harbour</td>
<td>430</td>
</tr>
<tr>
<td></td>
<td>Kirkley</td>
<td>149</td>
</tr>
<tr>
<td>Bury St-Edmunds</td>
<td>Risbygate</td>
<td>161</td>
</tr>
<tr>
<td></td>
<td>Abbeygate</td>
<td>118</td>
</tr>
</tbody>
</table>

96Social Inclusion Unit, Suffolk County Council.
There is also evidence that crime is linked to mental health: those who suffer from mental health problems are more likely to be victims of crime than commit crime, they are also more likely to suffer mental health problems such as depression.\textsuperscript{97}

\section*{5.7 Vulnerable People / Groups}

For the purposes of this document, a person or group is vulnerable when support is required to enable or promote independent living and safe and active participation in the community. Local, regional and national agencies are involved in targeted work to plan and commission services for these vulnerable groups. This section therefore only provides a short summary of some of the issues affecting them and may not cover all vulnerable groups. Reference is given to further information in each section where available.

\subsection*{5.7.1 Teenage Mothers}

Teenage pregnancies are not necessarily unintended, but for many young girls and their babies there are poorer health outcomes than for older mothers, as well as social and economic disadvantage. The figure below shows that although the teenage pregnancy rates in Suffolk are lower than those for England as a whole, rates in Waveney and Ipswich are significantly higher\textsuperscript{98}. This demonstrates the presence of another vulnerable group in Suffolk, whose health, social, educational and economic needs must be addressed. (See also Section 6.2)

\textsuperscript{97}Extract from “Indications of Public Health in English Regions” in Suffolk County Council’s Mental Health Vision.

\textsuperscript{98}Source: Office of National Statistics and Stephen Patterson, Suffolk Primary Care Trust.
**5.7.2 Young Carers**

Young carers are children and young people under the age of 18 years who provide care to another family member who has:

- A physical illness or disability
- Mental health difficulties
- Sensory disability
- Learning difficulty or disability
- A problematic use of drugs or alcohol

According to the Children and Young People [Performance handbook 2007], there are currently 129 young carers supported by the Suffolk Carers Young Carers Project, which aims to support young people who are caring for a relative at home.\(^{100}\)

It is interesting to note the difference between this figure and the number of unpaid young family carers in Suffolk according to the 2001 census, which is put at 1603, and includes 123, who provide over 50 hours of care per week.

The Young Carers Project has found that children and young people who help to look after someone at home are often disadvantaged because of their responsibilities. Although Young Carers are often mature for their age, many find it difficult to make friends and their school work may also suffer. Because of this Young Carers can experience low expectations, depression, bullying, and feeling that no one understands their situation. Within the family they may need help with the practical side of their caring role and the needs of the person that they care for. Young Carers are often very proud of what they do for their family.\(^{101}\)

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\(^{99}\)Suffolk Family Carers website.

\(^{100}\)CYP services Performance Handbook 2007.

\(^{101}\)Suffolk Young Carers Project, Suffolk Family Carers.
5.7.3 Transient Populations

Work undertaken by the Suffolk New and Emerging Issues Forum and the Multi Agency Forum for Refugees and Asylum Seekers in September 2007 has highlighted the similarities of issues faced by Gypsies and Travellers, Migrant Workers and Refugees and Asylum Seekers, particularly in accessing health care services in Suffolk. Barriers to access are often experienced and listed below for each community group. Some other issues creating barriers to access include:

- Poor literacy skills
- Lack of knowledge and understanding about what is available
- Lack of information in an accessible format
- Transport issues
- Transience of the community

Gypsies and Travellers

Gypsies and Travellers include Romany gypsies (the largest minority ethnic group among the Travelling communities in Britain), travellers of Irish heritage, and new travellers (people who have adopted this way of life for a variety of reasons including homelessness, unemployment or environmental issues).

Like other minority ethnic groups Gypsies and Travellers have their own language, culture and traditions. The lack of public sites and the difficulties they have in setting up their own sites has often forced them back on the road, with no fixed address. However, like any other community, Gypsies and Travellers need to access services, including schools, shops and health services.

Some of the health care issues faced by Gypsies and Travellers include:

- Lifespan for men is 10 years lower than average, while for women it is 12 years lower; birth and infant mortality rates higher than in the settled community.
- Often not registered with a GP, so access care via Accident and Emergency.
- Lack of consistent GP care exacerbates problems accessing services such as care for disabled children.
- Poor literacy skills have caused parents to misread medicine instructions and inadvertently overdose children.
- Gypsies and Travellers are more prone than the settled community to heart disease.
- Women have higher rates of mental health issues and diabetes than the settled community.
- Smoking and alcohol-related problems are high amongst the Gypsy and Traveller community.
- Late presentation and lack of early intervention services impacts on the health of this community.

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A survey of travelling community in Kessingland (Waveney) found that, in addition, child health was considered an important issue, in particular low immunisation rates and undiagnosed eczema and asthma (see Section 8 for more details on this survey).103

Migrant Workers

Migrant workers are people who migrate from one country to another for the primary purpose of work, whether permanently or temporarily. As many as one in three employers in the sectors where migrant workers principally work – agriculture, construction, health provision, food processing, hotels and catering, cleaning and manufacturing – employ migrant workers.104 Traditional patterns of migration are changing with seasonality of agricultural workers giving way to different agricultural methods requiring workers year round. See Section 2 “Ethnicity” for more details on migrant populations.

Research by the East of England Regional Assembly found that a sense of well-being and of integration by migrant workers in the region is affected by a number of factors.105

- Their financial situation, together with their ability to send remittances to their family;
- The yearning for contact with family members, but also the concern at their inability to adequately provide for family members who have travelled with them;
- Inadequate and expensive accommodation, which is sometimes unsafe and insecure; and
- Difficulty in accessing English language courses designed to meet their needs.

In addition, some of the health care issues faced by migrant workers include:106

- Inappropriate Accident and Emergency (A&E) attendance as many migrants are not familiar with the UK system which separates primary and acute care.
- Some migrants prefer to go to A&E even if they are registered with a GP, as they perceive fewer barriers to accessing care at A&E.
- An increase in maternity cases, with many not booking late appointments having not accessed available ante-natal care.
- Many migrants are not aware of their rights to health care.
- Lack of appropriate information acts as a barrier to accessing available health care.
- Infectious diseases often not picked up at initial screening. Further problem of people who have returned from visits home whose immunity has reduced; pick up infections during the visit.

103 Health Care for Members of the Travelling Community, Waveney Primary Care Trust.
105EEDA, 2006.
106Issues faced by migrants, refugees and asylum seekers, and Gypsies and Travellers in accessing health care services”, November 200.
Refugees and Asylum Seekers

This is a highly vulnerable group with complex needs, including mental health problems, language and cultural needs as well as existing physical health problems, and need for screening and vaccinations for infectious diseases. They are particularly at risk when they first arrive in this country, as are those whose asylum applications have failed.

It is difficult to obtain exact data for the numbers of refugees and asylum seekers in Suffolk as immigration status information is not necessarily collected by the services with which they have contact, and they all may not have contact with the services specifically for the client group (Refugee Council, Suffolk Refugee Support Forum and Suffolk Community Refugee Team, Refugee Legal Centre).107

The Suffolk Community Refugee Team has seen 178 people seeking asylum and refugees in the period April to August 2007 and saw 280 different individuals in 2006/07. As a GP practice from years 2003 – 2006 the team had an average list size of 600 – 700 people but each year there would be 300 to 400 people moving on and off the list. The service has 1,726 people on its database some of whom have moved away and for some it is not known if they are still in the area. The Suffolk Refugee Support Forum have seen 600 individuals in the last 18 months and a further 400 individuals seen over the previous 5 years.108

Any asylum seekers and refugees are living in Ipswich but there are communities in Lowestoft and Bury St Edmunds and isolated individuals elsewhere in the county. The largest national groups are Iraqi, Iranian and Afghani with Kurds making up the largest ethnic group. However, there have been a wide range of different nationalities and seen and languages spoken for which there are isolated individuals or no local communities (e.g. Mongolian, Lingala, Amharic).

Providing adequate health care for a transient population is difficult, but is especially difficult for these groups with the added burden of language, cultural and emotional problems. (See Sections 2 and 8 for more information on the different communities in Suffolk).

Some of the health care issues faced by refugees and asylum seekers include:109

- Inappropriate use of Accident and Emergency
- Difficulties registering with a GP and unable to complete forms without assistance
- Lack of available interpretation impacts on services received by them
- Problems associated with late presentation
- Difficulties accessing help for chronic conditions, particularly if the right to remain is not resolved.

5.7.4 Issues for New Arrivals from Abroad

Suffolk is an increasingly diverse county with a relatively high level of overall population growth, a contributory factor for which is immigration from abroad. The profile of immigrants to the County has changed significantly over the years from consisting

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largely of Bangladeshi, Indian, Chinese and African-Caribbean groups towards Polish, Portuguese, Kosovan, Latvian, Slovakian and other Eastern European nationalities (see Section 2.)

5.7.5 Homeless People

This is a highly vulnerable group within Suffolk. It is known that many of the homeless are under age children, and adults with drugs, alcohol and mental health problems. Homelessness and deprivation are very closely connected. Issues that contribute to homelessness include unemployment, family and relationship breakdown, debt, loss of tenancy from a private landlord, drugs and alcohol dependency.

Local authority housing departments have a statutory responsibility to deal with homelessness in their area and to provide temporary accommodation to people who fall into their “priority needs” group:\[110:

- People with dependant children
- Pregnant women
- Someone that is less able to find accommodation for themselves due to age, mental health problems, physical or learning disabilities or illness.
- Anyone that has been made homeless due to a disaster such as a fire or flood.

Anyone over the age of 16 can apply to a Council as homeless, however certain people are not eligible for assistance; for example those subject to immigration control as determined by the Asylum and Immigration Act 1996.\[111 More information on homelessness is available from district and borough council websites in Suffolk.

A significant proportion of these new arrivals are located in Ipswich, followed by the other urban areas and parts of Forest Heath. There are still however a number from this new wave of immigration to Suffolk living in more rural areas. These new immigrants report language and housing difficulties as being key issues they face as well as access to services and community cohesion with their new local communities (See Section 8 for more information).

5.7.6 Adults at Risk of Abuse (Adult Safeguarding)

Abuse, and the fear of abuse, has a significant impact upon an individual's ability to maintain and maximise their health and well being. There is an increasing recognition both nationally and locally that the issue of safeguarding adults needs to be on the same statutory footing as child protection.

In 2006/07 1153 adults who were thought to be victims of abuse were referred to Suffolk Adult Social Care services. Of these, 63% were women and 37% men. The majority of referrals came from Lowestoft, followed by Ipswich and Bury St. Edmunds. The majority of referrals (563 or 49% of the total) were for older people, followed by those with learning disabilities, for whom there were 369 referrals (32% of the total).

\[110 Forest Heath District Council, Strategic Housing Service, website.
\[111 Forest Heath District Council, Strategic Housing Service websites.
96 referrals were made for those with mental health problems and 67 for those with physical disabilities.112

Given the fact that the elderly are the group most likely to be victims of abuse and the large growth in the elderly population of Suffolk forecast to happen over the next fifteen years (See section 2), as well as an increased awareness of vulnerable adults, it is possible that the incidences reported for this group will continue to rise significantly in future years.

Family members were most frequently accused of being the abuser, which may be related to the fact that the most frequent setting for abuse is the victim’s own home. Over half the reported instances of abuse were classed as either physical or financial.

112The Suffolk Adult Safeguarding Board (ASB) Annual Report 2006/07.
5.7.7 Domestic Violence

Domestic violence is any incidence of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults who are or have been intimate partners, or are family members, regardless of gender. Domestic violence occurs across all society. Those who experience violence and abuse and those who are violent and abusive come from all backgrounds, irrespective of social class, income, level of education, occupation, sexuality, gender, age, ethnicity or race, physical or mental ability.

There were 5515 reported incidents of domestic violence in Suffolk in 2004/05, a 16% increase on the previous year. However, domestic violence is vastly under reported. The Home Office estimates that only 35% of incidents are reported. Many unreported incidents could include serious injuries that are treated through the NHS but victims are reluctant or afraid to report to police.

National statistics show that:

1. 1 in 4 women will experience domestic abuse at some time in their lives
2. On average 2 women are killed every week by their partner or ex partner
3. Over 50% of women using mental health services have experienced domestic violence
4. 89% of victims suffering sustained domestic violence are women
5. Women are more at risk when they are pregnant – over 30% of domestic violence starts at pregnancy
6. Children living with domestic violence are at risk of significant harm from direct abuse or witnessing or hearing abuse
7. At least 1 million children witness domestic violence every year
8. Over three quarters of children on the risk register live in households where domestic violence occurs
9. Domestic violence accounts for over 25% of violent crime (similar figures in Suffolk)
10. The repeat offending rate is higher than any other crime (in Suffolk it is over 33%, 3 times higher than any other crime)
11. Those aged 46 -65 years of age may be less likely to report incidents to police having experience many years of abuse.

A Community Safety Audit carried out in Suffolk in 2003/2004 found that the highest incidences of domestic violence occurred in Waveney, Forest Heath and Ipswich. However, although Babergh, St. Edmundsbury, Mid Suffolk and Suffolk Coastal appear to have lower than average rates per 1000 population, it is important to note that victims living in rural areas face additional barriers to reporting. The Audit also found that in reported incidents:

- Alcohol or drugs were a factor in 44% of cases
- Children were present at 47% of incidents
- Where gender was given, 79% of the victims were female and 21% male
- A fifth of male victims were assaulted/abused by male perpetrators.
5.7.8 Prisoners

Suffolk hosts four prisons, and their inmates represent a significant and deprived population within our community. Hollesley Bay prison has 328 young adult males, Highpoint 792 and Edmund Hill 371 (both expected to increase) and Warren Hill has 214 males under the age of 18 years. Actual numbers vary, as this is a highly transient population, and this adds to the difficulties of adequately meeting their longer term needs. Both local and national needs assessment have shown that prisoners have a higher prevalence of physical and mental health problems especially, than the general population of similar age. Prisoners are known to often have lifestyles with high prevalence of risky behaviours including smoking, drugs and alcohol abuse compared with the general population.

5.7.9 Sex Workers

In late 2006 five women were murdered in Ipswich. In response to this and other national drivers, the Ipswich Prostitution Strategy 2007/12 has been developed in partnership between Suffolk County Council, Ipswich Borough Council, Suffolk Primary Care Trust, Probation and Suffolk Police. This complements the national Home Office document ‘A Coordinated Prostitution Strategy’ published in 2006.

The Strategy will identify the issues that currently prevent adults from being able to leave prostitution, such as benefits, housing and coercive/violent partners. It will then target those who wish to exit prostitution and ensure that they do so safely and through a coordinated multi-agency approach and plan. Kerb crawlers who are a concern will also be identified in a risk assessment process by the Police and Probation Service, and Anti-Social Behaviour Orders are being to used kerb-crawlers and to women are not compliant with the process.

In terms of inequalities, there are a number of factors that, taken together mean adults engaged in prostitution often don’t obtain adequate access to services. These are:

- The role itself which is extremely stigmatising for those involved and tends to be internalised by sex workers;
- The chaotic lifestyle which can limit their ability to access universal services, housing and their own children (80% have children);
- Domestic violence and violence from kerb crawlers and non-reporting of same, and
- Lack of access to domestic violence refuges because of drug use.
Drugs and Alcohol Misuse

Drugs and alcohol misuse has a considerable impact on people’s health, as well as on the family, community and workplace. The Suffolk Drugs and Alcohol Strategy\textsuperscript{116} recognises that some people will misuse drugs and alcohol and that a harm reduction approach is essential from a crime, health and social perspective. The Strategy highlights the need for a range of interventions including education, prevention, treatment; harm reduction and reducing and disrupting the supply of drugs. In particular, drug related deaths and people who inject drugs are of great concern as many drug users will be infected by blood borne viruses including Hepatitis C. There are also worrying trends of young people binge drinking, which links to anti social behaviour and there is evidence of long term health problems such as liver disease and cancer.\textsuperscript{117}

The Strategy has found that effective treatment helps individual drug misusers escape from addiction and crime and improve their health. Staff working in treatment or related fields have observed an increase in polydrug use and specifically greater use of alcohol, crack cocaine and cannabis. Geographically, most types of drug use appear to be countywide, although stimulant use was noted as being particularly prevalent in the west. There has been an observed increase in women presenting for treatment, particularly those involved in the sex industry. Drug workers report dealing with a higher number of child protection cases and dual diagnosis clients as well as more volatile clients. Homelessness was identified as problematic in those clients presenting to treatment services, particularly for younger people.

Table 5.13 shows the number of Suffolk residents in drug treatment during 2006/07. It should be noted that these figures are based on those postcodes that could be allocated to a CDRP* area. About 190 client records either did not have a postcode or could not be attributed to a specific area and consequently these have not been included in the analysis.\textsuperscript{118}

\textbf{Table 5.13 – Suffolk Residents in Drug Treatment during 2006/07}

<table>
<thead>
<tr>
<th>Source: National Drug Treatment Monitoring System (NDTMS)</th>
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<tbody>
<tr>
<td>CDRP* area</td>
</tr>
<tr>
<td>Babergh</td>
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<tr>
<td>Ipswich</td>
</tr>
<tr>
<td>Suffolk Coastal</td>
</tr>
<tr>
<td>Waveney</td>
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<tr>
<td>West Suffolk</td>
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</tbody>
</table>

*Crime and Disorder Reduction Partnership
\(^\wedge\) numbers rounded to the nearest 10

\textsuperscript{116}Suffolk Drug and Alcohol Strategy 2005-2008, Suffolk Drug and Alcohol Action Team.
\textsuperscript{117}Suffolk Drug and Alcohol Strategy.
\textsuperscript{118}Suffolk Drug and Alcohol Action Team.
A study commissioned by the Eastern Region Public Health Observatory\textsuperscript{119} found that, in 2004/05, 30\% of men and 20\% of women regularly consumed more than the stated safe limit of alcohol in a week, with the 16-24 year age group regularly drinking more than the stated safe limit in greater numbers than any other age group. In addition, the Suffolk Alcohol Harm Reduction Strategy 2006\textsuperscript{120} found that current trends in alcohol misuse appear to be going up, and that with greater availability the numbers of problem drinkers in Suffolk has increased year on year.

Excessive alcohol consumption is not only a major cause of ill health and premature death, but is also a cause of accidents and a factor in many criminal offences (see section 5.7.7 on “Domestic Violence”) and other social problems. Suffolk currently has 6.8 crimes per 1000 population attributable to alcohol, although less than the English average (10.5) and low for the eastern region (7.9) it does vary from 12.2 to 3.7 depending upon locality.

The Alcohol Strategy has identified a lack of recorded data on alcohol use and misuse in Suffolk, which has a significant impact on the ability to plan for the future. One of the main priorities in the Strategy is the establishment of robust data collection and audit system so that the partners can plan effective and timely interventions across the community, including vulnerable groups such as Gypsies and Traveller’s, emerging communities and people seeking asylum.\textsuperscript{121} In addition, the Drug and Alcohol Action Team is commissioning an Adult Drug Needs Assessment which will be completed in September 2008. It is hoped both pieces of work will inform the next JSNA.
Section 6: Children and Young People

Interesting Facts . . .

- Children and young people under 18 represent around 24% of the Suffolk population.
- The proportion of children from black and minority ethnic background in school is currently 7.4%.
- The school population is becoming more diverse: In January 2007, the school census recorded over 70 languages identified as pupils’ first language.
- 18% of 11-year olds in Suffolk were recorded as obese in June 2006, in line with national trends of rising obesity in children.
- There are over 400 children on the child protection register in Suffolk.
- Suffolk pupils perform at or above the national average in school attainment tests at ages 7, 14 and 16.
- Lowestoft has the highest proportion of young people not in education, employment or training at over 11%. Woodbridge and Kesgrave have the lowest at 2.54%.

Key Issues:

The Children and Young People’s Plan (CYPP) developed by the Children’s Trust Partnership is the primary vehicle for delivering action to drive improvements in the identified priority areas. In addition to this, there are a number of key areas around transition arrangements between children’s and adult services, which it would be useful for commissioners to consider jointly. These include:

- Child and Adolescent mental health services
- Disability support
- Accommodation for vulnerable young people,
- Substance misuse support
- Support for young carers

In 2005/6 a joint needs analysis was carried out to support the development of the statutory Children and Young People’s Plan122, which was published on behalf of the Children’s Partnership Trust Board in June 2006. In May 2007, a review of the first year of the Plan was completed to report on progress and to assess if the priorities identified through the original needs assessment were still relevant. This work has also been externally assessed through the Joint Area Review (JAR) inspection process, and validated against an extensive toolkit provided by Ofsted to give a full picture of what it is like to be a child in Suffolk.

This section provides a summary of this work, focusing on the priority areas identified through the Needs Assessment, Children and Young Peoples’ Plan and Joint Area Review process. The analysis is structured around the Every Child Matters ‘Change for Children’ agenda, which identifies five outcome areas important to all children. These are:

- Being healthy
- Staying Safe
- Enjoying and Achieving
- Making a Positive Contribution
- Achieving Economic Well-being
Despite growth in the overall population of Suffolk described in Section 2, total numbers enrolled in Suffolk schools are forecast to continue the decline experienced over the last four years. There will however be areas of growth. The Office for National Statistics 2006 mid-year estimates record 159,300 children and young people aged less than 19 years old in Suffolk.

The profile of the child population is changing. 7.4% of the school population is from a minority ethnic background and school populations are becoming more ethnically diverse, with increases among most groups other than Chinese. Data from the school census in January 2007 shows that amongst school age children, the fastest growing groups are from Portugal, India and Eastern Europe. Over 70 different languages are now recorded as the First Language of pupils in Suffolk pupils.

Groups of children especially vulnerable to poorer outcomes have been identified. These include Children Looked After (in public care), children on the Child Protection Register, children with additional needs associated with learning difficulties or disabilities, and those living in disadvantaged areas. Any child may experience periods of vulnerability due to changes in family circumstances. These groups are shown in figure 6.1 below.

Figure 6.1 Children vulnerable to poorer outcomes (numbers registered in boxes)

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SEN stands for special educational needs.
6.2 Being Healthy

In May 2007, the ‘Suffolk Tell Us’ survey, conducted by the Children’s Trust Partnership using Viewpoint on-line technology, sought to gain the views of young people in Suffolk on a range of issues relating to the five Every Child Matters Outcomes outlined in the introduction to this section. The survey was completed by a total of 333 children from four schools. This built on a survey of 1800 children and young people undertaken in 2005 as part of the original needs assessment for the Children and Young People’s Plan.

Children and young people in Suffolk are generally positive about their health, with 89% describing themselves as ‘very’ or ‘fairly’ healthy, and 91% describing their lives as “quite” or “very enjoyable”. There were big differences between genders however; whilst 45% of boys described themselves as ‘very healthy’, only 29% of girls felt the same. In the same survey, 15% of children and young people identified that they were stressed “almost all the time”.

The data on children’s health shows a broadly positive picture. The percentage of babies born with low birth weight – an indicator of potential health problems later in life - is lower in all parts of the county than the England average. Immunisation is taken up well, though the rate for the measles, mumps and rubella take up at 84% is slightly lower than the desired rate deemed necessary to give protection to the community at large. 83% of pupils take part in 2 hours per week of sport or physical exercise after school. However, national trends for rising obesity in children are evident in Suffolk, with almost 9% of five-year olds and 18% of 11-year olds recorded obese in June 2006. Halting and reversing this trend is a Local Area Agreement and Children and Young People’s Plan target; to improve the immediate and long-term health and well-being of these children and young people.

The emotional health and wellbeing of children and young people is recognised as an important factor in them being able to fully reach their potential. Early intervention and preventative support is offered to parents, with multi-agency support (health, social care and education) offered through the expanding number of children’s centres across the county. Schools address this issue in a number of different ways: over two thirds are now participating in the National Healthy Schools Programme and 120 schools in the County are using the Social and Emotional Aspects of Learning (SEAL) programme. Additional primary mental health workers are being recruited to respond to the need for improved access to mental health services at the stage of early identification and support, and so reduce the demand for specialist services and problems later on in life.

Data on teenage conceptions shows a promising return to the downward trend in 2003, with a reduction of 15.2% from the 1998 baseline. This is ahead of the national rate. The 2005 conception rate is 31.7 per 1,000 15-17 year olds equating to approximately 400 conceptions, with around 52% continuing to birth. (See also Section 5.7.1).

A key priority is to provide high-quality, confidential and accessible advice to support young people in avoiding risk-taking behaviour, and so further reduce the rate of teenage conceptions and the risk of Chlamydia and other sexually transmitted infections. Local strategies for achieving improved outcomes in this area include good quality sex and relationships education in schools, informed and trained staff, and a sustainable expansion of school-based health services.

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Timely access to substance misuse and mental health assessment and interventions for the most vulnerable young people, such as young offenders, excluded pupils and looked after children is an area for improvement.

Priorities for the Suffolk Children’s Trust Partnership in 2007-2008 will be:

- Reducing childhood obesity
- Reducing teenage conceptions
- Further improvement to child and adolescent mental health services

### 6.3 Staying Safe

The ‘Suffolk Tell Us’ Survey showed that most children in Suffolk feel safe, with over 80% reporting that they ‘feel safe’ both in school, when walking to school and in their local communities. Bullying is considered to be a problem by 49% of young people, with 13% having experienced bullying ‘often’ (higher for girls). This is an area identified for further work.

Relatively fewer children in Suffolk are killed or seriously injured on Suffolk roads, compared with other comparable areas in England. The number of children and young people killed or seriously injured on Suffolk’s roads has been reduced by 51% during 2006. Further work is planned to target the 16 to 18 age group who are at the highest risk of death or serious injury. Activities to raise awareness of safety issues have involved schools, and included road safety initiatives such as school travel plans, pupil participation in Walk to School Week and cycling training.

Deprived neighbourhoods have been targeted, and foster carers have received information and advice on helping children to be aware of safety issues. Progress has been achieved in partnership with the fire service to focus attention on safe home environments. As a result, specific actions have been identified for 2007-2008, including the targeting of high-risk groups to reduce the risk of fire.

There have been a series of targeted actions aimed at ensuring that children and young people in care are safe, have stability and achieve their full potential. The numbers of Looked After Children has remained broadly the same at around 700 children, though there is a pattern of more 0-1 year olds coming into the care system. There are around 400 children on the Child Protection Register. This equates to 27.5 per 10,000 under 18s – a higher rate than in other similar authorities.

Partnership initiatives are focusing on prevention and minimising the number of children needing to enter the care system. The development of family support services alongside children’s centres which give priority to local delivery of preventative multi-agency services are being developed, building on the recommendations from an extensive review.

Performance measures in relation to looked after children and child protection remain good, with 90% of looked after children reviews being undertaken within timescales. All children and young people who are looked after have an allocated social worker and multi-agency plans that are reviewed appropriately.
Priorities for the Children’s Trust Partnership in 2007-2008 will be:

- Reduce numbers of young people killed or seriously injured on Suffolk’s roads
- Reduce the perception of bullying and persistent bullying
- Children and young people in care, with particular attention on the likely enhanced requirements resulting from Care Matters and ensuring young people leaving care achieve their potential.

6.4 Enjoying and Achieving

The level of educational attainment is a key determinant of future success in children and young people and has direct links with the future health and wellbeing status of individuals. A good education allows higher future income and choice leading to improved outcomes.

High quality early years provision has contributed to good outcomes in the foundation stage profile, and the pattern of performance above national expectations continues in assessments at the end of Key Stages 1, 3 and 4. The focus on underperformance at Key Stage 2, especially in the three-tier system brought attainment levels in English back to the national average in 2006, and better gains in mathematics than seen nationally. 87% of pupils consider that they are doing ‘very’ or ‘quite well’ at school (Suffolk Tell Us Survey, 2007).

Most black and minority ethnic groups perform in line with national expectations, and there have been encouraging gains by some groups. There is a continuing need to target black and minority ethnic group resources towards raising the achievement of black pupils and to support the increasing number of schools that are admitting pupils whose first language is not English, especially those with no previous experience in working with these pupils. Although the Department for Education and Skills (DfES) targets for looked-after children were met, there is still work to do to ensure that better outcomes are achieved.

The outcomes of school inspections in Suffolk compare well with the national picture, with 19 ‘outstanding’ schools and few schools found to need significant improvement or special measures.

Attendance of pupils is above national averages and policies such as promoting Attendance and Behaviour Toolkits have helped to increase the number of pupils regularly attending school and maintained the reduction in permanent exclusions. Analysis has identified three key groups who are still not attending school with acceptable frequency: persistent absentees, parentally condoned absentees and those on fixed-term exclusion from school. In 2007/08 the focus will be to secure improvements for these groups.

There are now increased opportunities for children and young people to be involved in recreational and leisure activities outside school. Suffolk’s target for the number of schools offering access to a wide and varied menu of activities was exceeded, and our Extended Schools work has been recognised by the Training and Development Agency as one of the best nationally. A significant number of young people have already engaged in the Suffolk Children’s University. A third ‘Playing for Success’ centre has opened in Oulton Broad to serve schools in the north of the county. The percentage of children involved in at least two hours of physical activity has also been increased, and a greater number of children and young people with physical disabilities are involved in out-of-school activities.
A significant problem - confirmed by many children and young people - is the lack of convenient affordable transport to allow them access to sporting, cultural and recreational activities. Pilot transport projects will provide valuable information about the feasibility of overcoming this barrier.

Priorities for the Childrens Trust Partnership in 2007/08 will be:

- Attainment of children and young people
- The extension of informal learning, leisure and cultural activities

### 6.5 Making a Positive Contribution

There are increasing opportunities for young people to influence and inform decision-making in Suffolk.

Some examples include:

- Young people with additional needs involved in commissioning services - from design to procurement and involvement in interview panels.
- Involvement of young people in recruitment of all front line staff in the Vulnerable Children and Integrated Youth and Connexions services
- Involvement of pupils in interviews for headteachers. New headteachers report back that this can be one of the toughest parts of the interview, and young people report on feeling real ownership of the process and gaining an insight as to what is required to be a head.
- Young people were involved in the recent consultation on the School Organisation Review that led to a commitment from Councillors to involve them in the next stage of the process.

In the 2007 Suffolk Tell Us Survey, 59% of young people said it was easy for them to have a say in the way things were run in their school: with 37% feeling their opinions would make ‘a little difference’ and an encouraging 17.5% felt they would make ‘a lot of difference’. This will be fed back to school councils to debate.

Young Suffolk’s Millennium Volunteer Partnership exceeded the target of 88,000 hours volunteering to 118,000 hours and funding has been secured to deliver 100 full-time volunteering experiences over the next 2 years. Young Suffolk has secured funding to engage young people in at least 39,750 hours of part time volunteering.

The Youth Offending Service has been successful in developing preventative work with children and young people who have offended or are at risk of offending, with a 9% reduction in the number of first time offenders from 1,241 to 1,131 in 2006/7. During 2006-2007, all young people on these Time2Change programmes were tracked, and 92% did not go on to re-offend. As a result of recent data showing that 42% of young people re-offended within twelve months of being released from custody, the Youth Offending Service has developed a performance strategy which focuses on substance misuse and mental health, both of which are issues known to impact on re-offending levels.

Transition between schools particularly for vulnerable children can be a major challenge. All Year 9 pupils with a statement of special educational needs were sent the ‘Your Choice’ booklet and DVD. This led to them stating that they felt more confident in
changing schools. 181 young people with learning difficulties or disabilities (LDD) were supported to access mainstream leisure activities, and there are increasing numbers of young people who have a dual placement with a mainstream and special school, as part of a strategy to increase inclusive experience for young people.

Work to support young carers (See Section 5) has developed this year with the introduction of peer support groups and opportunities for young carers to socialise. Young carers have reported how valuable this opportunity to meet with other young carers has been for them. The Ipswich Caribbean Experience, a project for Black and Minority Ethnic pupils that challenges stereotypes and misconceptions has been externally recognised as a model of good practice. The Youth Offending Service and partner agencies have recognised the disproportionate numbers of black and minority ethnic young offenders and have launched a project aimed at reducing social exclusion amongst black and minority ethnic young people. A commitment to promote positive images of children and young people in Suffolk as part of the communication strategy has led to a change of design in publications and an increase in the number of positive stories in the media.

Priorities for the Children’s Trust in 2007/08 will focus on:

- Embedding the active involvement of young people in practice across the partnership
- Reporting back to young people on the impact of their involvement on service delivery
- Supporting schools and other providers in addressing social cohesion.

6.6 Achieving Economic Well-Being

This outcome area looks at how parents are supported in balancing childcare and job demands, and how young people themselves are supported in securing qualifications and a successful transition to independent adult living.

There is a wide range of childcare provision in the County. The quality of childcare provision is good and increasing in volume with a net gain of over 19,000 places created by April 2007.

Suffolk is on target to establish 35 children’s centres by March 2008. Children’s centres are designed to enable families to benefit from a wider range of services as well as high quality day care, particularly in the most disadvantaged areas. Good links between health visitors and family workers have secured the involvement and engagement of hard-to-reach families in urban and rural settings. All children’s centres provide signposting to employment and benefit advice linking to Jobcentre Plus.

Ensuring that children and young people live in decent homes free from poverty is a priority in the Children and Young People’s Plan, requiring coordinated action across the district and borough councils. The Young People’s Housing Action Group, with multi-agency representation has established a strategy and action plan for 2007-2008 that covers needs and provision assessment, homelessness, support, information and guidance, as well as housing development.

The Suffolk 14-19 Strategy provides the central focus for ensuring young people achieve economic wellbeing. It is delivered by a local partnership of the Learning & Skills Council, the County Council, Connexions (now an integral part of the County Council), and numerous other local provider partnerships/consortia.
In the Audit Commission School Survey 2006, schools rated the effectiveness of provision for 14-19 year olds as above satisfactory (2.93). Whilst this is below the average for local authorities it represents an improvement on previous ratings. The Suffolk Tell Us Survey, 2007 shows that young people as well as schools believe independent advice and guidance could be more effective. This has been recognised by partners who are taking action to improve. Post-16 participation in structured learning has seen small increases since 2004. Increased numbers in further education have been sustained alongside some growth in the numbers returning to school sixth form. By contrast, smaller numbers of young people are opting for government-sponsored training or work based learning with an employer. The surge in the numbers progressing to higher education identified in 2005 has not been sustained in 2006, possibly due to the impact of changes in tuition fees. Post-16 participation remains a key priority for further work in all localities, with over 8% of young people 16-18 remaining in the NEET (not in education, employment or training) category as recorded in the November 2006 Connexions activity survey. If Suffolk students studying out of the county were included, a more positive outcome would be recorded. Figure 4.2 shows the areas in Suffolk that have the highest levels (red) of young people not in education, employment or training. The red areas map closely to areas with high levels of multiple deprivation and low income and highlight the multidimensional nature of deprivation and poor life chances.

Table 6.1 shows the specific wards in Suffolk that have the highest levels of young people not in education, employment or training.
Achievement at A-Level remains below the national average in terms of attainment and progress made by students. The rising trend in attainment as measured by average points per candidate has been sustained in 2006, although the national rate improved faster. The rise in success rates in the further education sector in Suffolk identified in 2005 has been sustained in 2006.

Support is provided to young people with learning difficulties or disabilities in transition and their parents through the Moving On events which provide a market place for advice/signposting, and through three multi-agency drop in centres/cyber cafes opened to provide information and advice.

In 2007/8 the Suffolk Children’s Trust Partnership will place special focus on:
- Participation in post-16 learning and activities
- Prevention of homelessness, and improvement to the housing offered to vulnerable young people

### 6.7 Transitional Arrangements

As young people progress into adulthood, those with additional needs may face specific issues concerning support from statutory services. Services geared specifically to children and young people may have different eligibility criteria and approaches to those offering services to adults. Transitional arrangements to protect those most vulnerable, and smooth the process, are helpful in ensuring these young people understand what is available and can access appropriate support.

Key areas for securing transition arrangement are:
- Child and Adolescent Mental Health Services
- Learning difficulties/disability support – especially to secure employment/training
- Accommodation for vulnerable young people – care leavers; teenage parents
- Substance Misuse support
- Support for young carers

<table>
<thead>
<tr>
<th>Locality area</th>
<th>% Of 16-18s NEET (2006)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lowestoft</td>
<td>11.02</td>
</tr>
<tr>
<td>Ipswich North and East</td>
<td>10.83</td>
</tr>
<tr>
<td>Ipswich South and West</td>
<td>9.24</td>
</tr>
<tr>
<td>Haverhill</td>
<td>8.37</td>
</tr>
<tr>
<td>SWISS where is this?</td>
<td>8.12</td>
</tr>
</tbody>
</table>
Section 7: Environment, Transport and Access to Services

Interesting Facts . . .

- 60% of Suffolk’s population live in 6% of the area.
- 43% of SOAs in Suffolk are amongst the 20% most geographically deprived in England.
- 2006 was the warmest recorded year for 277 years.
- 19 of the warmest years on record have occurred in the past 20 years.

Key Issues:

- Rural isolation can create significant barriers to accessing services for residents, particularly those who rely on public transport in the northern part of Mid Suffolk and rural Babergh.
- Mid-Suffolk has the highest projected growth in the elderly population but also the poorest access to services by public transport.
- Better protection from extremes in weather for vulnerable groups, including the elderly, as climate change impacts on Suffolk.
- Those living in coastal areas and areas at high risk of flooding (i.e. flood plains) are increasingly vulnerable as sea levels rise and weather becomes more severe.

The role of environmental factors, including transport, in influencing the health and wellbeing status of communities in Suffolk is significant. This is particularly so in rural areas where:

- Access to services can be incomplete.
- Populations tend to be slightly older.
- There is a high prevalence of fuel poverty.
- Older people tend to be more vulnerable to extremes in temperature, as demonstrated in the heat wave of summer 2005.

7.1 Car Ownership

Car ownership figures by household from the 2001 census can be used to show areas of economic deprivation i.e. places where some households cannot afford to run a car or where a car is not considered necessary. These figures are also useful because they may help to show us where there are pockets of rural isolation and poor access to services in Suffolk.

The vast majority of households with no cars are in the urban centres of Suffolk, where many people can easily walk to services and amenities. There are however also some more rural areas with low levels of ownership, notably in Southwold and Reydon, Beccles, Bungay, Brandon, Aldeburgh and Leiston and Saxmundham. A high concentration of one-car households may also be indicative of (rural) isolation, for instance for families where partners and children may be stranded in the home whilst the bread winner uses the only vehicle to get to work and back; it could also indicate areas with a high concentration of single person households. Two areas with low levels of ownership: Ringshall near Stowmarket and Pakenham north of Bury St. Edmunds, are both areas where many British military live.
The areas that have lower levels of car ownership also tend to be the same areas where growth in the elderly and very-elderly population is likely to be the greatest over the coming years, as well as being areas defined as rural and having poor access to services by public transport (See figure 7.1)

**Figure 7.1: Households with only one car by Super Output Area (Census 2001)**

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**7.2 Cycle Routes**

Access to rural cycle paths in Suffolk varies widely throughout the County. The Eastern area is relatively well served with the North-Sea Cycle Route, Suffolk Coastal Cycle Route and National Cycle Route 1 connecting the towns of Felixstowe and Ipswich in the South and Beccles, Bungay and Lowestoft in the North, as well as all the more significant conurbations in between.

Cycle routes connecting the Eastern and Western areas of Suffolk are far more limited, with only National Cycle Route 51 giving residents access from Bury St. Edmunds to the rest of the County. Areas with no access to rural cycle routes are largely in the Forest Heath, Babergh and St. Edmundsbury areas, specifically Brandon, Mildenhall and Haverhill. There appears to be a slight negative association between the affluence of an area and access to rural cycle paths, with the less affluent Eastern/Coastal areas of the County comparatively well served in relation to the more affluent northern and Southwestern areas.
7.3 Rural Isolation and Access to Services

In 2004, DEFRA, working in partnership with other agencies produced a method of categorising England and Wales into urban and rural areas\textsuperscript{125}. The urban areas have a population of 10,000 or more according to the 2001 Census, whilst rural areas are further subdivided through the identification of rural towns, villages and isolated dwellings. Both urban and rural areas are assigned a rating of ‘Sparse’ or ‘Less Sparse’ according to the density of the population in the local area.

When applied to Suffolk, the classification indicates that about 60\% of the residents of the County lived on just 6\% of the land area. Other than the area around Leiston, Suffolk has a dense scatter of settlements. Figure 7.2 below illustrates the classification (using the standard colour scheme).

*Figure 7.2: Rural/Urban Classification for Suffolk, 2005*

Separating rural from urban areas allows us to examine the different demographic and social characteristics of the two types of area. Comparisons of those aged 0-16 and 16-44 shows that the profile of those in urban areas is slightly younger than rural. This is reversed for those aged 45-74 and then becomes equal for those aged over-75, irrespective of whether the area is classified as rural or urban. This is the result of selective migration into rural areas by middle aged people and the departure of young adults.

\textsuperscript{125}See http://www.statistics.gov.uk/geography/nrudp.asp and http://statistics.defra.gov.uk/esg/rural_resd/rural_focus/rural_focus_la.asp
Inequality in access to services reflects the urban/rural split in the County, with parts of Babergh, St. Edmundsbury, Suffolk Coastal and particularly Mid-Suffolk consistently having the most limited access to services including Hospital A&E departments, GPs and dental surgeries. The area with the most limited access to these services is the area immediately west of Sudbury, South of Bungay, north of Woodbridge and parts of Babergh and St. Edmundsbury.

These results are strengthened by the Indices of Multiple Deprivation 2004 results for Suffolk, the Access to Housing, and Geographical Barriers domains support the above analysis and show that 182 of the Super Output Areas in Suffolk or 43% of the total are in the 20% most deprived nationally. The most geographically deprived area in Suffolk

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Figure 7.3: Age profiles of rural and urban Suffolk (2001 Census)

Figure 7.4: Access to GPs by public transport within 30 minutes by household
7.4 Climate Change

September 2006 was the warmest recorded in England in 277 years – July was the warmest month since 1659. 19 of the warmest years on record have occurred in the last 20 years.\textsuperscript{127}

Climate change is happening at a fast rate and it is likely that Suffolk will be affected, with temperatures predicted to rise by an average of between 2 and 5 degrees Celsius per year by the 2080s. This increase in temperature will likely be accompanied by rises in the sea levels, which, despite some uncertainty, may rise by between 23 and 42 cm by the 2090s.

These changes will be accompanied by wetter winters and drier summers, as well as by increased intensity and frequency of storms. Extremes of weather will become more common and adversely affect the most vulnerable groups and communities in the County.\textsuperscript{128}

The effect of these changes on the population of Suffolk are hard to predict, particularly due to a high level of uncertainty on the times-scales over which the changes will take place and on the precise nature and magnitude of the risk to Suffolk. There are however some groups and communities in Suffolk whose needs will change with the climate, and for which we may need to be prepared for in advance;

■ Coastal areas and areas located on flood plains are likely to experience increased flooding, and many homes and properties are likely to come under increased risk from erosion, particularly in the Suffolk portion of the Broads and the strip of coast between Felixstowe and Leiston. Residents in these areas may need additional protection. Much of the new building in Ipswich is in the floodplain.

■ Extremes in weather, both hot and cold, will cause the elderly and other vulnerable groups to suffer disproportionately. In the East of England higher mortality levels above the baseline were observed in the over 75 age group for the heatwave of 2006. It is likely that as climate changes, with hotter summers and milder winters, the extremes over the whole year will reduce with any peaks of deaths above the baseline occurring in summer in addition to winter. One example of a potential consequence of this may be that local authorities will need to consider supplying air conditioning units to the homes of vulnerable people in order to reduce the risk of harm as well as improved winter insulation preventing excess deaths and the associated costs of medical treatment (see section 2 for an analysis of the health issues of elderly and vulnerable people in Suffolk).

■ The rural population and agricultural sector may suffer if it does not respond appropriately to climate change, by changing the sorts of crops grown (to grapes, for example) and preparing adequately for new crop diseases that will flourish in the new warmer climate.

\textsuperscript{127}Www.cru.uea.ac.uk/cru/press/2006-12-cet-records/full.pdf
\textsuperscript{128}www.ecn.ac.uk/iccuk/indicators/9.htm
Section 8: Voice

Interesting Facts . . .

- Men, those aged 25-34, and those in socially rented housing are most likely to think that they live in an area where people from different backgrounds don’t get along together.
- Many residents say public transport needs improving in their area.
- Housing costs and language barriers are highlighted as major issues by the Kurdish, Polish and Portuguese communities in Suffolk.
- Young people, lone parents and Kurdish, Portuguese and Polish communities all said housing difficulties were one of the main issues they faced.

Key Issues:

- Suffolk residents say that more activities for teenagers, affordable decent housing and traffic congestion are the issues most in need of improving, according to the BVPI User Satisfaction Survey 2006/07. These same issues were also repeatedly raised by respondents in other consultations.
- Members of the Kurdish, Polish and Portuguese communities identified English language classes as needed to help them integrate into, and participate more fully with local life.
- The Sustainable Community Strategy consultation highlighted housing, transport infrastructure, public transport, crime and homelessness as key issues for residents in Suffolk.
- The number of recorded complaints by Adult Social Care may imply an issue of meeting the needs of older people in Suffolk.
- The increasing numbers of people with diabetes want greater access to written information so that they can better manage their condition.
- Many from black and minority ethnic communities want access to more information in their own language in places they regularly visit.

As well as the quantitative data collected on the population of Suffolk; there is also a wealth of qualitative information on residents’ views and priorities available that would benefit decision makers and commissioners alike. This information comes from a wide range of sources including consultation and survey responses, complaints reports, GP questionnaires and focus group reports. The range of sources used to compile this section is not exhaustive, but rather is designed to give the reader a snapshot of some of the key current and emerging issues facing the various different groups and communities in Suffolk. It is intended that future Joint Strategic Needs Assessments will involve more direct consultation and involvement of the population of Suffolk.
Between April and July 2007, the Suffolk Strategic Partnership (SSP) consulted with stakeholders on Suffolk’s Community Strategy Consultation Document, ‘Shaping the Future of Suffolk’ 2008-2028. This document sets out the partnership’s objectives for the next 20 years in the form of a number of key themes. A number of issues and areas of perceived need emerged from the consultation, which was conducted via a series of twelve focus-group discussions held in different locations and with different socio-economic groups.

- **Housing** – One of the main issues to emerge from the focus groups was the lack of affordable housing to buy and to rent; this is a greater problem for young adults in particular. There were also some concerns about the lack of council housing:

  “Where are these affordable places? There aren’t any in Ipswich. There are none. They spend hundreds of millions of pounds in the dock area, £100m in Woodbridge and Framlingham and all those sorts of places, but where are these affordable flats for people who are 18 or 19 years old?” (Male, Ipswich)

- **Transport Infrastructure** – This was identified as an issue for participants. In particular, road surfaces, congestion in towns and too many traffic lights in town centres were the main concerns coming from the discussions. In West Suffolk, concern was expressed about heavy traffic on the A14:

  “On the A14 we’ve got tractors, 36 tonne trucks, cars, elderly people and it’s a mix that is just ready to blow” (Female, West Suffolk)

- **Public Transport** – A number of issues were highlighted. The biggest concern was the bus service, in particular buses not being on time or not turning up at all, a lack of service on Sundays in some areas, inaccessibility for buggies or disabled users, the lack of shelter at bus stops and the cost being prohibitive for young people.

  “They’re never on time and not good for buggies. If you’ve got a child in a buggy you can’t get on.” (Female, Waveney)

- **Crime** – This was also perceived to be a major problem along with anti-social behaviour, vandalism and young people hanging around. Related to all these concerns was the perceived lack of police presence. These issues were particularly salient in Ipswich and Waveney.

  “There’s a growing drug problem here and drugs coming into Felixstowe along the A14 and people can get out of Bury very quickly that accounts for the growth in crime I think, people can get out quickly” (Female, West Suffolk)

- **Homelessness** – This was recognised as an issue by participants living in Ipswich and Waveney. The poor condition of hostels was a concern for some.
8.2 BVPI User Satisfaction Survey 2006/2007

8.2.1 Priorities for Improvement

This survey, which every local authority in England is obliged to carry out once every three years, was conducted by Suffolk County Council during late 2006 and early 2007. The survey looks at the public’s perception of topics such as quality of life, anti-social behaviour, public transport and environmental issues.

In 2006/07 Survey, respondents were asked what aspects of their local area most needed improving. The three top priorities in Suffolk were identified as:

- Activities for teenagers (50% of respondents)
- Affordable decent housing (35% of respondents)
- The level of traffic congestion (33% of respondents)

Also mentioned as priorities for improvement were public transport (30%), road and pavement repairs (30%) and the level of crime (24%).

The following table shows how different priorities can have different levels of salience for different communities and groups in Suffolk.

Table 8.1: Areas for improvement and their relevance to specific sub-groups

<table>
<thead>
<tr>
<th>Area for improvement</th>
<th>Key subgroup</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Activities for teenagers</td>
<td>Residents aged 25-34</td>
</tr>
<tr>
<td>2 Affordable decent housing</td>
<td>Residents who rent privately</td>
</tr>
<tr>
<td>3 The level of traffic congestion</td>
<td>Waveney residents</td>
</tr>
<tr>
<td>4 Public transport</td>
<td>Mid-Suffolk residents</td>
</tr>
<tr>
<td>5 Road and pavement repairs</td>
<td>Older residents aged 65 or over</td>
</tr>
<tr>
<td>6 The level of crime</td>
<td>Ipswich residents</td>
</tr>
<tr>
<td></td>
<td>Residents ages 55-64 years old</td>
</tr>
</tbody>
</table>

Note that as each respondent was asked to select three priorities, the figures above don’t sum to 100%.

Percentages may also not sum to 100%, as respondents were each asked to list three priorities from the list.

8.2.2 Social/Community Cohesion

The Survey asked respondents to what extent they agreed or disagreed with the statement that “this local area is a place where people from different backgrounds get on well together.” The groups that disagreed with this statement the most were respondents aged 25-34 and those who live in social rented housing. Almost a third of respondents from Forest Heath (29%) also disagreed with this statement, followed by 21% from Ipswich, and 19% from Waveney.

8.2.3 Anti-Social Behaviour

When asked how much of a problem they thought a range of different anti-social behaviours were, Suffolk residents stated that the key ones were:

- Parents not taking responsibility for the behaviour of their children (55%)
- Teenagers hanging around on the streets (49%)
- Not treating each other with respect (38%)

The above were listed as issues in all part of Suffolk. Some notable local differences are however:
Ipswich: People not treating each other with respect and consideration (46% vs. 38% overall) and Vandalism, Graffiti, and other deliberate damage to property or vehicle (38% vs. 30% overall) were identified by respondents as key issues.

Forest Heath: Drug use and dealing drugs was highlighted as the most important issue, in sharp contrast to the rest of the County (62% vs. 36% overall), as was the presence of abandoned and burnt out vehicles (23% vs. 10%)

**Figure 8.1 - Social Cohesion: Subgroup Analysis**

In the first half of 2007, the Suffolk Speaks Partnership, which has representation from the Suffolk District and Borough Councils (excluding Ipswich), The Police Authority and Constabulary, and Suffolk County Council, consulted with a range of ‘hard-to-reach’ groups in the County in order to ascertain what these groups felt were the main issues they faced. Each District/ Borough Council chose the two hard to reach groups whom they considered most salient to their area. See Appendix 4 for a table describing what groups were consulted in which areas. The following section summarises the main findings of this project by group/community.

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These two groups had broadly similar needs and desires, although there were still some differences in the detail.

- **Housing** – Sudbury was highlighted as an area with particular problems surrounding accommodation, with high rental costs and shortages of housing leading to some cases of homelessness.

- **Language** – This was identified as the main barrier to finding employment and accommodation in the County, accessing information about services, and generally integrating into community life. The need for English language classes held at appropriate times and of a high intensity was highlighted. Language was also felt to link strongly with community cohesion, feelings of belonging and being settled and happy.

### 8.3.2 Kurdish Community (Ipswich)

This group originates mainly from the Kurdish areas of northern Iraq, and in many cases have been resident in the County since the early years of the century. Although their issues are broadly similar to those of the Polish and Portuguese groups, they were keen to highlight the fact that their circumstances were very different from these other groups.

- **Language** – The main barrier to integrating with the local community was identified as language difficulties and the lack of effective English language teaching in the area. Language was seen as a barrier to understanding their rights and accessing appropriate services.

- **Employment** – Many Kurds feel that they are in the catch-22 position where they need education/language skills yet are under pressure to get jobs below their capabilities in order to support themselves. Negative attitudes from potential employers were also seen as an issue.

- **Housing** – Rental costs and long waiting lists for council housing were cited as major difficulties for the Kurdish community, as were difficulties in understanding the process and accessing people who are in a position to help.

### 8.3.3 Established Households (St. Edmundsbury)

The participants in these focus groups highlighted the fact that the worst aspect of living in the area was transport in its many forms, including congestion on the A14, poor bus services between towns, problems for cyclists, and nuisance HGVs on rural lanes.

Participants also raised the issue of services, employment opportunities and amenities being located outside of villages. The point made was that some villages are now dormitory communities, as many of the services traditionally provided inside villages are not surviving.

### 8.3.4 Lone Parents (Ipswich, Lowestoft)

Negative aspects for the Lowestoft area included drink and drug related nuisance from neighbours, lack of employment opportunities, lack of facilities, poor transport and poor policing. In Ipswich the issues were difficulty in finding work, prejudice towards lone parents, disruptive behaviour from young people and unsafe parks.
Housing – Accommodation difficulties were the main concern for lone parents, including the length of time on the waiting list for council housing, inadequacies of upkeep of council housing and high rents and high deposits required in the private sector. There was also criticism of perceived favouritism towards foreigners in the allocation of council housing.

GPs – Difficulty of access to GPs was mentioned by both the Ipswich and the Lowestoft focus groups. In the latter, participants complained of surgeries closing down and moving away from the area.

8.3.5 Young People (Mid-Suffolk, Forest-Heath, Babergh, Suffolk Coastal)

Those who participated highlighted crime and disorder, drink, and drugs as being issues that led to intimidation and feelings of unsafety. One reason for these was that there was ‘nothing else to do’ – a frequently voiced complaint during the meetings.

Facilities: The need for more facilities, including nightclubs and cinemas was highlighted. Lack of facilities was considered to lead to vandalism and underage drinking. It was felt that places where young people can ‘hang out’ such as outdoor shelters should be provided. Poor public transport was also seen as a major issue.

Employment – Poor/expensive transport to work was highlighted as a big problem, as was a general shortage of well-paid work. Undergraduate participants also expressed little hope of securing a job in their area.

Accommodation – There was general pessimism surrounding buying property in the local area due to the disparity between wages and house prices. Rising prices were also a concern. Finding accommodation of any type in rural areas was also highlighted as a problem.

Community Cohesion – Generally this was not seen as a problem, although there was some unease about the potential impact upon British people of the influx of workers from overseas. Leiston however was different. Participants voiced particularly negative feelings towards foreigners, who were blamed for recent increases in the crime rate. Leiston participants were also vocal about the arrogance of tourists and the number of holiday homes in the area, particularly Aldeburgh.

8.4 Suffolk Speaks: Our Communities Speak Project 2002/2003

An earlier project that the Suffolk Speaks Partnership funded between 2002 and 2003 examined the views of black and minority ethnic groups on public involvement and access to services. Members of the African-Caribbean, Bangladeshi, Chinese, and Sikh communities were consulted to find out their views on access to services. It should be noted that since it has been some time since this consultation took place, some of the issues raised i.e. access to computers, may have changed and therefore the points raised below should be treated with some caution.

Key crosscutting issues raised by these groups in the consultation revolved around the following points:
Leaflets need to be translated and made available in places the different community members regularly attend.

Better access to translators.

More council staff from black and minority ethnic communities needed to be seen.

Awareness sessions for different communities about various services and how to access them.

Each individual black and minority ethnic community raised slightly different issues regarding knowledge of and access to services. The key points are reviewed below.

### 8.4.1 African-Caribbean Community

- People either didn’t know or knew very little about the services that Social Care (Now Adult and Community Services and Children and Young Peoples’ Directorates) provided.
- Older people felt that since they had made National Insurance contributions they should have access to a better NHS.
- Few knew how to use a computer, although this could have been because the project was conducted in 2002/03, when a lower percentage of the population had access to computers.
- There should be more information in places where members of the African-Caribbean community can access it.
- People said that there should be more awareness about mental health problems for men (See section two for more information on mental health issues in Suffolk.)

### 8.4.2 Bangladeshi Community

- Most people were unaware of Social Care Services.
- Those consulted said they would seek the help of family members in the first instance if they needed advice about Social Care or the Health Service.
- They wanted to see more staff from ethnic communities.
- People said there should be ‘awareness sessions’ held on the services offered, particularly for older people, by public organisations in the places they visited such as community centres and mosques.

### 8.4.3 Chinese Community

- People said that if they needed to contact social care or the health services they would ask a family member to make contact on their behalf or go to the Chinese Family Association to make contact.
- They wanted to have information and leaflets translated and for them to be in places they visited i.e. Chinese Association.

### 8.4.4 Sikh Community

- Awareness of the services provided by Social Care and Health was low.
- Consultees said that having information translated, posters in community centres, leaflets given out with prescriptions, publicising of services in places they go and employing more staff from black and ethnic minority backgrounds would encourage them to access services more frequently.
### 8.5 Travelling Community in Waveney

A report by Waveney Primary Care Trust's Public Involvement Manager (Health Care for Members of the Travelling Community) in a site in Kessingland, found that the health issues for travellers in Kessingland were:

- Unwillingness to access health care at GP surgeries but willing to discuss issues with GPs visiting the site.
- Fear of discrimination by public health officials.
- High levels of alcohol use and abuse in some families.
- High instances of abuse against women in some families.
- Poor diet.
- Higher percentage of smoking leading to higher prevalences of associated long-term conditions.
- Child health was considered a big issue, in particular low immunisation rates and undiagnosed eczema and asthma.
- Vital work needs to be done to build trust with traveller communities.
- Communication was key.

### 8.6 Adult and Community Services – Complaints Register

Suffolk County Council's Adult and Community Services (ACS) directorate received 540 complaints in 2006/2007. Older people and those with a disability, or someone complaining on their behalf made up the majority of these complaints. Of those that gave their ethnicity, 71 were ‘white British’ and 1 was ‘other white’.

Many of these complaints were about the lack of/delay in accessing residential and respite care, especially specialist care for people with dementia and care for people with learning disabilities. There were also complaints about the delay in providing home care following assessment.

A number of complaints were received about the reduction in funding to different voluntary organisations and concerns that this would result in a reduction in services, in particular Halesworth ACCESS.

Carers not visiting at the agreed time or not staying for the length of time agreed on the care plan were also a reason for complaints.

The reasons for complaints outlined above may be indicative of a lack of capacity in the system to meet the needs of all residents in a timely and quality manner. Given the demographic trends likely to occur in Suffolk over the next 15 years leading to very significant increases in demand for older persons and care services (see Section 2), as well as the lean budgetary situation in Suffolk at the moment it is likely to be an increasing challenge to meet the increasing needs and demands of the growing elderly population in the County.

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The Primary Care Trust Board has a duty to consider the complaints received on a quarterly basis. In the six months from October 2006, Suffolk Primary Care Trust had received 91 compliments and 62 complaints. Nearly a third of the complaints were about commissioning issues such as waits for orthodontic treatment, 24% were about policy issues such as funding for new drugs, 15% were about levels of service, and 11% were about staff or treatment.

Between January and March 2007, the Patient Advice and Liaison Service had received 483 enquiries. Of the issues raised, 62% concerned dental services.

The results of the Department of Health 2006/07 GP patient survey showed that on most measures, people in Suffolk were slightly more satisfied with access to their GP services than those in England as a whole. 89% of those surveyed in Great Yarmouth and Waveney Primary Care Trust and 91% of those in Suffolk Primary Care Trust were satisfied with telephone access to the surgery, and 90% and 91% respectively were able to arrange an appointment within 48 hours. Booking an appointment in advance was slightly more difficult, with only 72% and 78% of patients being satisfied. In terms of opening hours, Waveney Primary Care Trust and 20% in Suffolk Primary Care Trust said they would like their surgery to be open later in the evening, and 51% and 61% wanted Saturday morning opening. However, differences were found in the national survey between those from older age groups, those from different ethnic groups, those from areas of deprivation and those from rural areas who were all less satisfied with these issues than the general population. This needs to be noted in the further development of local general practitioner services.

Between January 2006 and May 2007 a Residents Perception Study conducted by Priory Research Services was conducted. The aim of this consultation was to find out what some of the key issues and concerns were to residents in their neighbourhoods.

The main issues singled out in the consultation related to neighbourhood concerns such as the need for an increased police presence, better services with more activities for children and young people, and improvements to the living environment such as increased rubbish collections. Alongside these localised issues, respondents also had concerns about the town in general, such as improved road links (especially a third river crossing) and improved employment opportunities. Respondents felt that in order for the situation in their area to be improved, that these more general issues for Lowestoft as a whole would have to be addressed.
Section 9: Analysis of Key, Cross-Cutting Issues

Key Issues:

- In rural areas of Suffolk, evidence suggests some key issues are rural isolation and poor public transport, the high price and low supply of housing for locals and fuel poverty for many pensioners and other vulnerable people.
- There is an unbalanced age profile in rural areas, with low proportion of younger people and higher proportion of middle aged people.
- In market towns in Suffolk, evidence suggests that many of the key issues residents face are similar to those in more rural areas. There do appear however to be differences in terms of higher levels of anti-social behaviour and, in some but not all market towns, increasing community cohesion issues between established residents and new arrivals.
- In urban areas in Suffolk, evidence suggests that some of the key issues are high levels of multiple deprivation, a younger age profile than many of the more rural areas of Suffolk as well as more ethnically diverse populations. Housing is more affordable and access to services and amenities easier.
- Antisocial behaviour and criminal damage in market towns appears to be associated with a lack of things to do for young people, whereas in urban areas it is strongly associated with low income and deprivation levels.
- In the future, people will increasingly be expected to remain economically active into retirement. This may conflict with their dual role as family carers. As the population ages and the emphasis turns from older people being dependent on support and social services to being independent and empowered this will become an increasing issue.
- Older people can no longer rely upon family for care either because (a) families are dispersed geographically, (b) many older middle aged women are at work, (c) there are more single person households so no one around to help.
- Inequality in Suffolk is multidimensional; the places with the lowest income also tend to have the highest levels of multiple deprivation, the highest levels of anti-social behaviour and the lowest level of educational attainment. More work is needed to determine the key drivers behind this multi-dimensional inequality in Suffolk.
- In many cases the numbers of individuals known to statutory services with particular conditions are lower than the prevalence rates suggest there are.

This section is intended to draw together some of the key themes, issues and strands identified in the preceding chapters, and to use them to draw a holistic picture of the issues faced by many of those in the County. The section will start by looking at the issues that affect the rural areas of Suffolk, before moving on to what can broadly be described as ‘market towns’, and then examining the more urban areas and larger towns. After this a number of crosscutting issues will be analysed, including the dual role elderly people will increasingly be encouraged to play in the future and the multidimensional nature of inequality in Suffolk.
9.1 Rural Areas

Some of the issues and characteristics of the more rural areas of Suffolk are similar to those faced by market towns. There is however some striking differences, with rural areas:

- Generally not as deprived and with relatively high levels of income. The exception is rural Waveney and the northern part of Suffolk Coastal, which has higher levels of deprivation. (Indices of Multiple Deprivation 2004)
- Lower levels of crime and antisocial behaviour. This is often not the case however in the rural hinterlands immediately adjacent to urban areas, including market towns.
- More physically active populations, with the exception of rural Waveney. (Active people Survey 2006)
- Higher skills levels than market towns generally, but still a mixed picture across the county.
- Larger numbers of single pensioner households, particularly in rural Waveney and the northern part of Suffolk Coastal. (Census 2001)

And some of the similarities are:

- Poor access to services by public transport leading to increase rural isolation. This is especially acute in the northern part of Mid Suffolk and the area immediately east of Sudbury, (See Figure 7.4).
- Mixed picture in terms of population growth, with some areas of decline in North and South Suffolk.
- Acute fuel poverty in many areas, especially Waveney and the northern part of Mid Suffolk.

9.2 Market Towns

There are a relatively large number of market towns in Suffolk. These are often located in relatively isolated areas away from services and amenities. They tend to be rural in character with relatively poor access to amenities and leisure activities compared to the larger towns. Whilst different market towns will have distinct local identities and cultures, there are also a number of characteristics that this document has shown they share in common. Market towns in Suffolk:

- Are likely to experience high growth in their elderly populations in the future.
- Are likely to experience large increases in demand for age-related services in the future.
- Have higher levels of anti-social behaviour and criminal damage than surrounding areas. Results from consultations with local people (see Section 8) suggest that one reason for this may be that they (particularly young people) have limited access to amenities such as cinemas and clubs, resulting in boredom and higher levels of anti-social behaviour and a rising fear of crime. This is in contrast to anti social behaviour in more urban areas which seems to be more strongly associated with income poverty and deprivation, although it is very difficult to say whether these issues are the cause of anti-social behaviour.
- Have higher levels of fuel poverty, particularly in the northern and eastern areas of the County, and often in the same areas that have higher numbers of older people.
- Have poorer access to services by public transport, making issues such as rural isolation more of a problem for some people.
- Are likely to have low income and also low unemployment.
- Have lower skills levels those other parts of the County with high numbers of young people not in education, employment or training in many market towns.
- Are likely to have community cohesion issues. This appears to be emerging in some market towns, particularly Leiston (See Section 8).
- Affordable housing for young people and first time buyers appears to be a major issue, particularly in Babergh and Mid Suffolk where many market towns are located.

### 9.3 Urban Areas

60% of the population of Suffolk live in only 6% of the land area (see Section 7). These urban areas have a number of features, some of which may be similar to those faced by market towns, although the underlying causes may be different.

Some of the characteristics of urban areas identified in this document are:

- High levels of multiple deprivation when compared to rural areas and market towns.
- The ten super-output areas in Suffolk that are amongst the 10% most deprived in England are located either in Ipswich or Lowestoft. More deprived areas are associated with a number of risk factors including higher smoking and binge drinking levels.
- Younger age profile than rural areas.
- More diverse than many rural areas with large numbers of new National Insurance registrations for newly arrived foreign migrants, particularly in Ipswich.
- Lower life expectancy than many rural areas.
- High levels of anti-social behaviour, although there seems to be a closer link to deprivation than in market towns where there appears to be a stronger link with not having enough things to do.

**But:**

- House prices are more affordable. Ipswich is the most affordable district in Suffolk with the lowest ratio between the house prices and average incomes.
- Access to services is much less of a barrier than in many rural areas and market towns.
9.4 The Multi-Dimensional Nature of Inequality and Poverty in Suffolk

One of the main issues that the JSNA has identified repeatedly has been the multi-dimensional nature of deprivation and inequality in the County. The places that have low levels of income also tend to be the places with the least active populations, highest levels of criminal damage, as well as have the poorest scores in the Indices of Multiple Deprivation.

Based on the findings of previous sections, some of the key issues that may have some responsibility for the high level of inequality between Waveney (and other poorly performing areas) and the rest of the County are:

- Geographical isolation combined with poor transport connections leading to reduced private sector investment.
- Low skills base combined with ‘brain drain’ of skilled individuals. This may be leading to an inability to capitalise on technological and innovative creative industries that are now responsible for a large proportion of the growth in many parts of the world (Castells, 1996). Skilled/educated individuals tend to leave the area in search of better opportunities.
- Low income.
- An ageing population, leading to fewer economically active people in the area contributing to the economy, and who must also support the growing care needs of the elderly population.
- Community cohesion: The multidimensional nature of deprivation in parts of Suffolk may cause community cohesion issues to become more pronounced. Indicative signs that this may be happening are shown in Section 8.
**Section 10: Shared Priorities and Future Planning – Next Steps**

As identified at the beginning of this report, The Department of Health sees the JSNA as a critical tool to inform the commissioning intentions of primary care trusts and social care services as well as to inform development of the Sustainable Community Strategies and Local Area Agreements.\(^{133}\)

In the case of Children and Young People, the JSNA should be seen as a complement to the statutory Children and Young People’s Plan 2006-09 produced through the Children’s Partnership Trust.\(^{134}\)

The examples below show practically how Suffolk partners are utilising the JSNA to inform targeted, collaborative and joined up working for the next 3 year period.

**10.1 Influencing Development of the Next Local Area Agreement (2008-12)**

The Local Area Agreement Block 3 Adults and Healthier Communities Partnership Board have set up a sub group to develop an Adults’ Health and Well Being Plan. The findings from this JSNA will feed into the development of this plan along with the following criteria that will be essential for setting shared priorities in Suffolk:

- the Block 3 vision and strategic goals
- quality criteria for service developments/interventions
- shared strategic service development priority areas
- national priorities and targets
- service effectiveness - clinical or a cost benefits of specific interventions

The sub-group are currently researching all of the above and a priority setting workshop has been set up for January 2008 for all members of Block 3 to prioritise the collaborative/joint priorities taking account of the criteria above – these priorities will be recommended as priority/target areas for the LAA (2008-12) and will form the basis of the Health and Well Being Plan for Suffolk which will set out the direction of travel and priorities (supported by implementation plans) for the next 3 year period.

**10.2 Linking Into the Commissioning Cycles of Partner Organisations**

The organisations who have contributed to this JSNA have separate, but similar annual business planning process (linking strategy, targets and priorities to a financial schedule) underpinned by a generic commissioning cycle similar to the one below:

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\(^{134}\)The Children and Young People's Plan is underpinned by a joint needs assessment which was carried out with partners in 2005/06 and reviewed in 2007 as part of the annual review of the Plan.
The JSNA findings can be used as a basis for evaluation and review of existing commissioned services in Suffolk in order to ensure that existing services delivered are:

- Meeting the health and well-being needs of the service users
- Providing clinical and cost effectiveness
- Addressing priorities, nationally and locally driven

The local government Best Value methodology could form the basis of this service review/evaluation framework although a future workstream in Suffolk could give consideration to a joint approach to service review and evaluation, particularly for the services that are jointly planned and/or commissioned.

10.3 Influencing Service Reviews and Evaluations

The JSNA findings can be used as a basis for evaluation and review of existing commissioned services in Suffolk in order to ensure that existing services delivered are:

- Meeting the health and well-being needs of the service users
- Providing clinical and cost effectiveness
- Addressing priorities, nationally and locally driven

Information from the JSNA can be used to inform the commissioning intentions for programme areas e.g. commissioning for older people, mental health, learning disabilities, etc.
10.4 The JSNA as a ‘Live’ Resource

This JSNA will inform planning and commissioning for the next 3-year period but to take account of fluctuations and changes in demography, health and well-being factors, new research findings, etc. A workstream could explore the potential for the JSNA to be reviewed on an annual basis to inform the annual business planning process of individual organisations and joint commissioners.

There is also potential for the JSNA and primary data sources to be stored in an electronic portal that can be accessed by the County Council and two PCTs (and potentially other organisations). This portal could include ‘real time’ information of the primary data sources used to inform this JSNA reflecting the most up to date position upon which planning and commissioning decisions can be made.
Appendix 1

a) Primary data needed for the Joint Strategic Needs Assessment, as set out in the Draft Commissioning Framework for Health and Wellbeing (for guidance only).

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1 Demography</strong></td>
<td></td>
</tr>
</tbody>
</table>
| Population numbers | Current population estimates x5-year age bands and gender  
P: Population projections 3-5 years’ time  
% Change |
| Births | Current births and projected rates |
| Older people | Current total aged 65+, male and female and five-year projection |
| Ethnicity | Current numbers, percentages and projections |
| Benefits data | Children under 16 in households dependent upon Income Support |
| Deprivation | IMD 2004 |
|   | Housing tenure  
Living arrangements/over-crowding  
No access to car or van  
Employment data  
Average incomes  
Rural or urban location |
| **2 Social and environmental context** |   |
|   |   |
| **3 Current known health status of population** |   |
| Illness and lifestyle | British health survey 2004  
Quality and Outcomes Framework GP QMAS data  
Risk factor data (smoking prevalence) |
| Teenage conceptions | Age <16 rate plus 95% CI  
Age <18 rate plus 95% CI |
| Census 2001 | Standardised limiting long-standing illness ratio (persons in household) |
| Social care | RAP 3: Source of referrals  
P1: Clients receiving community-based services  
RAP P2f: Clients receiving community-based services  
RAP C1: Carers  
SWIFT |
| Primary care | Predicted prevalence versus known prevalence of x diseases  
Dental: % DMFT 5-year-olds – trend  
Immunisation: Resident-based uptake rates |
| Hospital care (HES data) | Top 10 causes of admission  
Top 10 diagnoses consuming most bed days  
Average, median and range of length of stay |
| Social care | User surveys  
PALS/Link data (qualitative and quantitative)  
Complaints data |
| Primary and community-based care | GPAQ  
Complaints data  
Self-reported health outcomes |
| Hospital care | Patient satisfaction surveys |
| **Patient/service user voice** |   |
| **Public demands** |   |
| Local authority | Annual residents survey  
Health scrutiny reports |
| NHS | Petitions received |
Work Requiring Further Research/ Analysis

This document has identified a number of issues that require further work by partners and which should be included in the next JSNA. Below are some of the key issues:

1. **The JSNA as a “Live” Resource**

   There is potential for the JSNA and primary data sources to be stored in an electronic portal that can be accessed by the County Council and two Primary Care Trusts in Suffolk (and potentially other organisations). This portal could include ‘real time’ information of the primary data sources used to inform this JSNA reflecting the most up to date position upon which planning and commissioning decisions can be made.

2. **Ways of Sharing Information Across Organisations**

   The JSNA development has highlighted the need for the NHS and local authorities to share information in a more structured way. This will avoid duplication of effort and a more rounded, holistic view of health and wellbeing in Suffolk.

3. **Number of People with Disabilities**

   This document has noted that the number of individuals with sensory, physical and learning disabilities known to social care services is lower than national prevalence figures suggest they should be (see Section 3).

   More work is needed to determine the extent to which these discrepancies represent genuine unmet need or can in fact be explained by other factors such as eligibility criteria. It is important to know the total number of individuals because of the role statutory services have in supporting and developing the market even if not offering/delivering services to everyone.

4. **Migration Flows**

   Migration demographics show a great fluidity of movement and diversity of people but there is a need to understand the flows between regions and the impacts upon health indicators. Local modelling of inflows and outflows is required with an understanding of where migrant groups are moving to and when, how long they may stay and why and how they might move between UK and home.
Appendix 3

1. Adult and Community Services Summary Finance 2006/07

![Pie chart showing service distribution]

ACS 2006/7 Revenue Budget

<table>
<thead>
<tr>
<th>Service Type</th>
<th>2006/07 (,000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Libraries &amp; Heritage</td>
<td>8,564</td>
</tr>
<tr>
<td>Services to Older People</td>
<td>81,277</td>
</tr>
<tr>
<td>Services to People With Physical or Sensory Disabilities</td>
<td>13,202</td>
</tr>
<tr>
<td>Services to People With Learning Disabilities</td>
<td>27,718</td>
</tr>
<tr>
<td>Services to People With Mental Health Problems</td>
<td>7,606</td>
</tr>
<tr>
<td>Services to Other Adults</td>
<td>1,150</td>
</tr>
<tr>
<td>Services to all Customer Groups</td>
<td>3,074</td>
</tr>
<tr>
<td>Strategic Management Services</td>
<td>5,653</td>
</tr>
<tr>
<td><strong>2006/07 Budget</strong></td>
<td><strong>148,244</strong></td>
</tr>
</tbody>
</table>
2. **Suffolk Primary Care Trust Spend Analysis by Top-10 Areas 2006/07**

![Suffolk Spend Analysis Chart]

- Mental Health Problems: 15%
- Circulation Problems (CVD): 12%
- Other (sub-category of MH problems; excludes substance abuse and dementia): 12%
- Cancer & Tumours: 11%
- Gastro Intestinal System Problems: 7%
- Musculo Skeletal System Problems (excludes trauma): 7%
- Gastro Intestinal System Problems: 7%
- Other Areas of Spend/Conditions: 17%
- Respiratory System Problems: 6%
- Special Care Needs: 7%

3. **Great Yarmouth and Waveney Primary Care Trust Spend Analysis by Top-10 Areas 2006/07**

![Great Yarmouth and Waveney Spend Analysis Chart]

- Mental Health Problems: 16%
- Circulation Problems (CVD): 11%
- Other Areas of Spend/Conditions: 15%
- Cancer & Tumours: 10%
- Gastro Intestinal System Problems: 8%
- Musculo Skeletal System Problems (excludes trauma): 8%
- Trauma and Injuries (includes burns): 8%
- Other (sub-category of MH problems; excludes substance abuse and dementia): 10%
- Respiratory System Problems: 7%
4. Children and Young People’s Directorate Finance Summary 2006/07

<table>
<thead>
<tr>
<th>CYP 2007/08 Revenue Budget</th>
<th>(,000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northern Area</td>
<td>8,000</td>
</tr>
<tr>
<td>Southern Area</td>
<td>10,252</td>
</tr>
<tr>
<td>Western Area</td>
<td>7,790</td>
</tr>
<tr>
<td>Vulnerable Children</td>
<td>17,297</td>
</tr>
<tr>
<td>Directorate Management and Resources</td>
<td>11,019</td>
</tr>
<tr>
<td>Education (Schools / LEA)</td>
<td>447,600</td>
</tr>
<tr>
<td><strong>2007/08 Budget</strong></td>
<td><strong>501,898</strong></td>
</tr>
</tbody>
</table>
## Appendix 4

**Suffolk Speaks Partnership: Social Inclusion and Community Cohesion in Suffolk Project 2007**

Target Groups Chosen by District/ Borough Councils

<table>
<thead>
<tr>
<th>District</th>
<th>Target group 1</th>
<th>Target group 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Babergh</td>
<td>Portuguese migrant workers</td>
<td>Single parents in areas if multiple deprivation</td>
</tr>
<tr>
<td>Forest Heath</td>
<td>Young adults</td>
<td>Polish migrant workers</td>
</tr>
<tr>
<td>Ipswich</td>
<td>Single parents</td>
<td>Kurdish community</td>
</tr>
<tr>
<td>Mid-Suffolk</td>
<td>Young adults</td>
<td>Portuguese migrant workers</td>
</tr>
<tr>
<td>Suffolk Coastal</td>
<td>Young adults</td>
<td>Polish migrant workers</td>
</tr>
<tr>
<td>St. Edmundsbury</td>
<td>Young adults</td>
<td>Polish migrant workers</td>
</tr>
<tr>
<td>Waveney</td>
<td>Established residents</td>
<td>Polish migrant workers</td>
</tr>
</tbody>
</table>