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Public Health & Communities

Core20PLUS5 in Suffolk

Evidence Base & Additional Information

Suffolk Annual Public Health Report 2022

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Introduction to the evidence base

- This evidence base is designed to complement the main slide set for the Suffolk Annual Public Health Report 2022 – focused on Core20PLUS5.

- Some of the slides duplicate content from the main report- but this is intentional, and whilst the slides are designed to be read together, it is also important that they can be read independently of each other.

- The data and information within this slide deck:
  - Summarises the recommendations from the main report
  - Explains what Core20PLUS5 is
  - Looks at the Core20, the PLUS populations and the 5 areas of focus for Suffolk through data and insights into our local communities

Recommendations

The Integrated Care Boards (ICBs) covering Suffolk should:

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

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

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

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

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

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

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

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

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

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So what is Core20PLUS5?

Fundamentally Core20PLUS5 is an approach to reducing health inequalities

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

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

Source: NHS England

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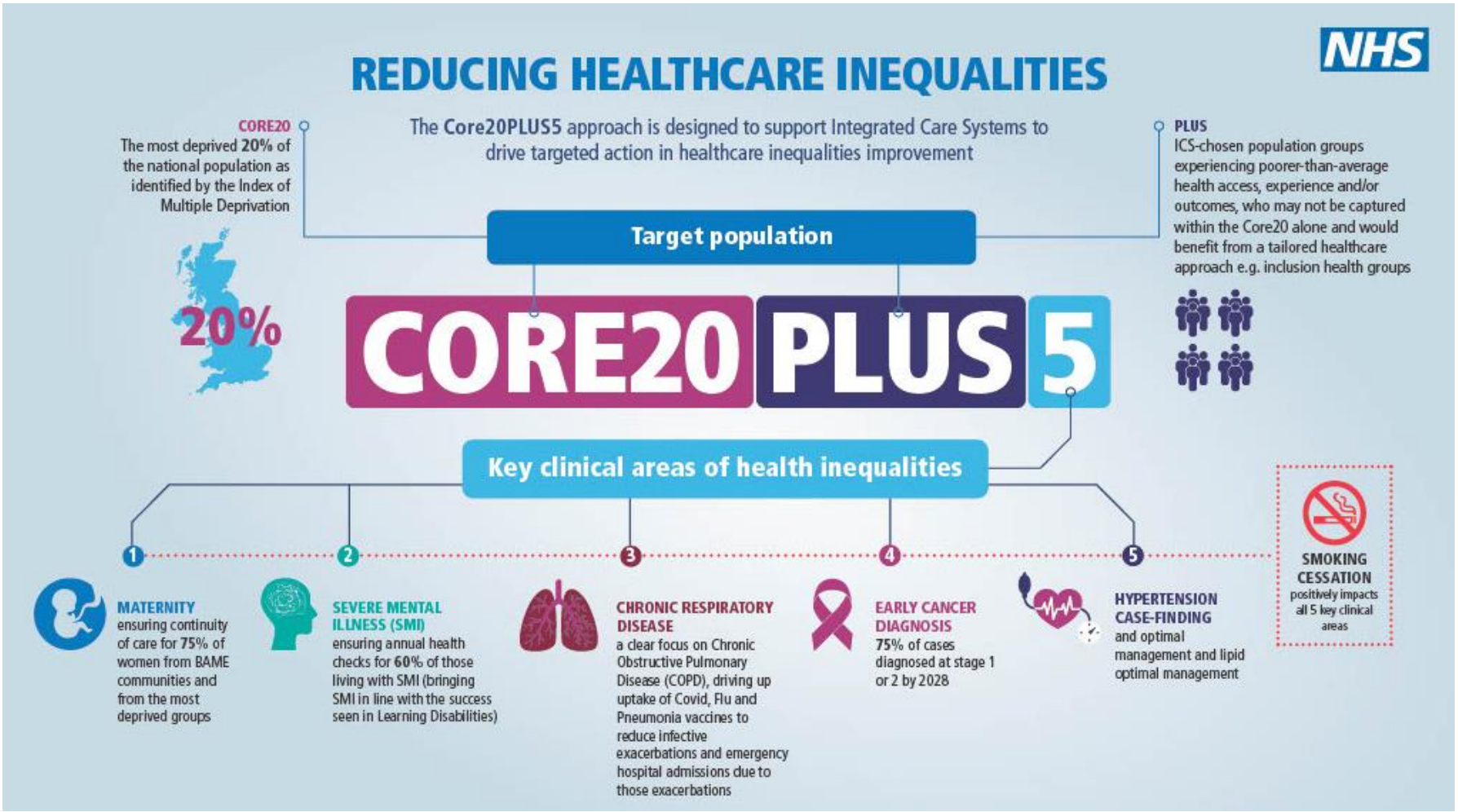
Core20PLUS5 components:



Source: NHS England

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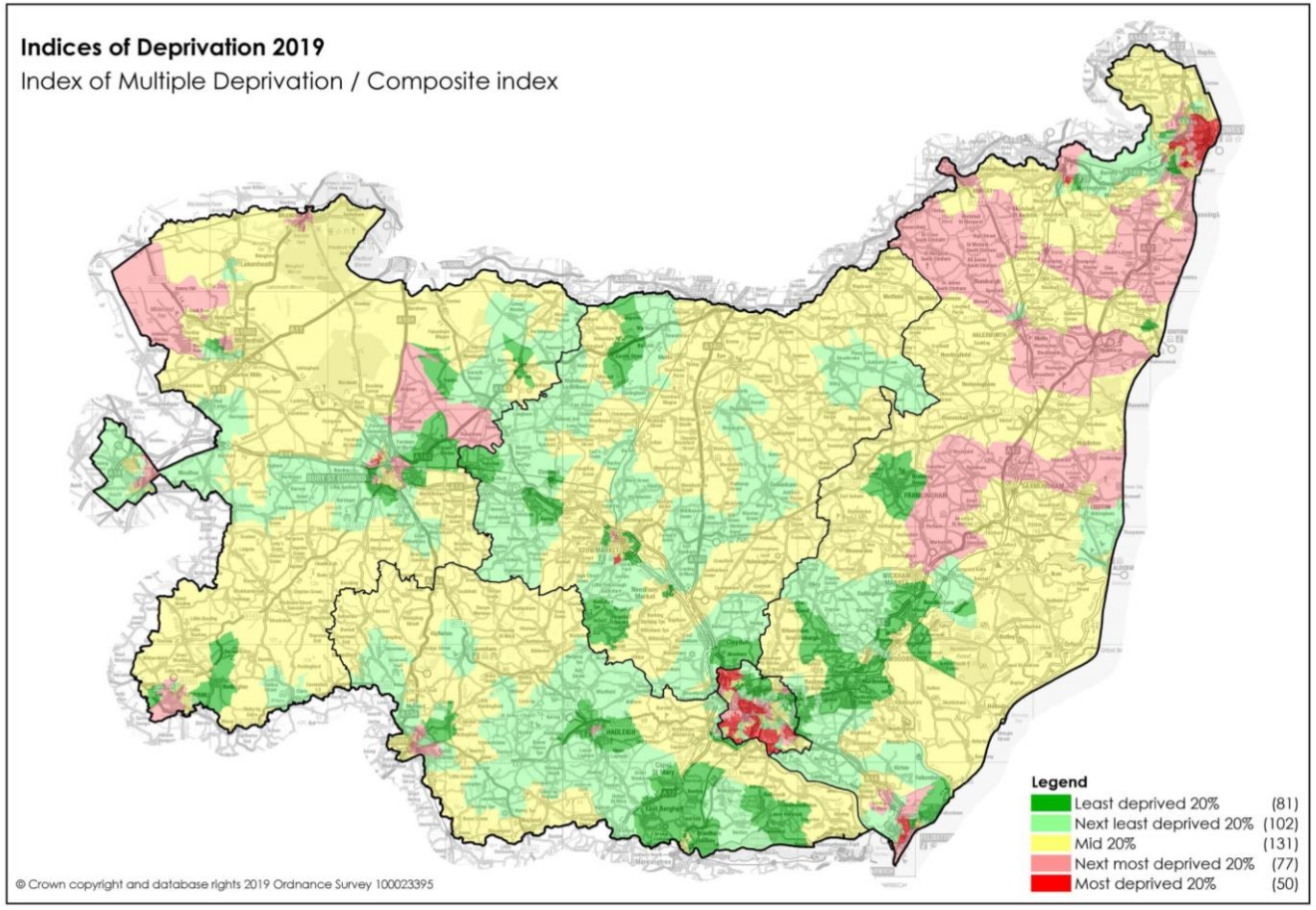
What the current data tells us about… Suffolk's Core20:



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

Source: 2020 mid year estimates, Indices of Deprivation 2019

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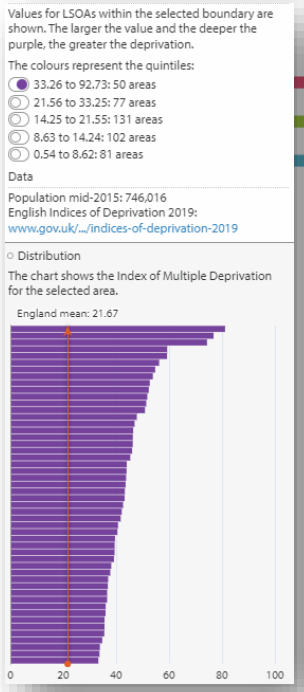
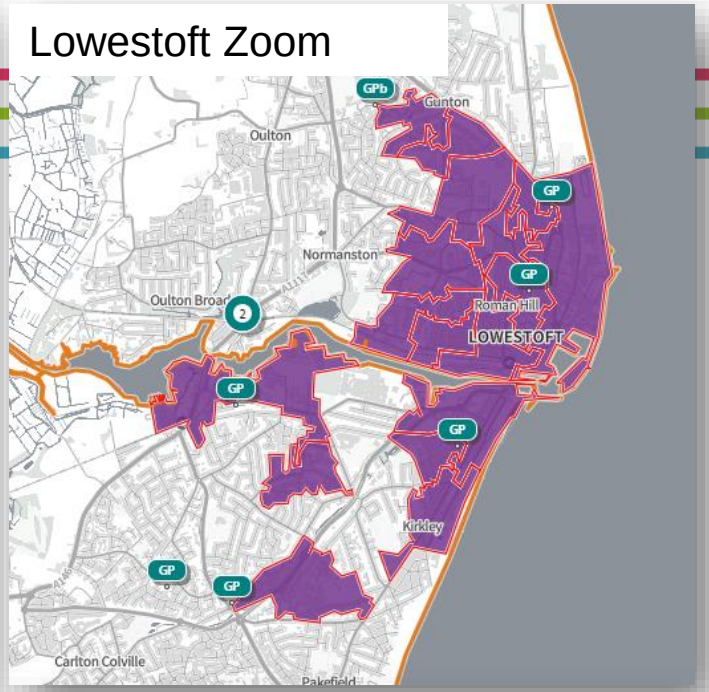
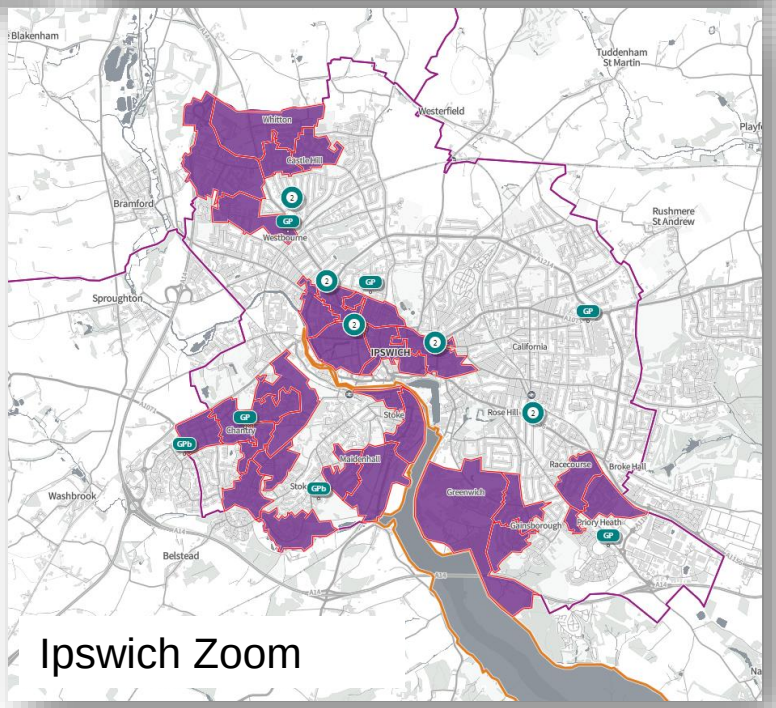
A closer look at deprivation:

- Using the Strategic Health Asset Planning and Evaluation application (SHAPE) tool, we can look at deprivation at a more granular level.
- In the table below **GPs located in areas with high deprivation** have been filtered for Suffolk. Predominantly these are in Lowestoft and Ipswich, however Haven Health in Felixstowe is also in the top quintile for deprivation.
- The England mean is 21.67.







GP	Area	Deprivation Score (for the Lower Super Output Area)
High Street Surgery	Lowestoft	76.81
Orchard Medical Practice Ipswich	Ipswich	53.86
Alexandra & Crestview Surgeries	Lowestoft	52.69
Haven Health	Felixstowe	43.76
Kirkley Mill Health Centre	Lowestoft	39.42
Burlington Road Surgery	Ipswich	39.17
Cardinal Medical Practice	Ipswich	37.77
Hawthorn Drive Surgery	Ipswich	36.57
Barrack Lane Medical Centre	Ipswich	35.52

Source: Strategic Health Asset Planning and Evaluation application (SHAPE)

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Local data to support the '5' – what do we know now?

The data for these measures should be collated within local health systems:

Area	Availability
Maternity: ensuring continuity of care during pregnancy for 75% of women from Black, Asian and minority ethnic communities and from the most deprived groups	Maternity services in SNEE have not yet rolled out continuity of care during pregnancy although in line with the maternity inequalities programme and National Maternity Transformation Programme Suffolk Trusts have approved plans to prioritise commencement in deprived communities and where people from minority ethnic families reside. James Paget hospital launched their continuity of carer model in February 2021. Commencement is based upon a critical number of qualified midwives being recruited. Limited data is available to support monitoring of this indicator
Severe mental illness (SMI): ensuring annual health checks for 60% of those living with SMI (bringing SMI in line with the success seen in learning disabilities).	Available at practice level for monitoring
Chronic respiratory disease: a clear focus on Chronic Obstructive Pulmonary Disease (COPD) driving up uptake of COVID, flu and pneumonia vaccines to reduce infective exacerbations and emergency hospital admissions due to those exacerbations	Available at practice level for monitoring
Early cancer diagnosis: 75% of cases diagnosed at stage 1 or 2 by 2028.	Available for monitoring at district and borough level (emergency presentations available at GP level)
Hypertension case-finding: to allow for interventions to optimise blood pressure and minimise the risk of myocardial infarction and stroke	Piloted within population health management programme Available at practice level for monitoring

Coming soon to support Core20PLUS5…

The **Healthcare Inequalities Improvement Dashboard (HIID)is in development, with some elements already published.** It builds on learning from the COVID-19 pandemic around the importance of good quality data to provide insights to drive improvements in tackling healthcare inequalities.

The dashboard measures, monitors, and informs actionable insight to make improvements to narrow health inequalities.

It covers the five priority areas for narrowing healthcare inequalities in the 2021-22 planning guidance. It also covers data relating to the five clinical areas in our Core20PLUS5 approach.

Data will be made available at ICS level, and can be tracked and fed into monitoring work.

Source: The Healthcare Inequalities Improvement Dashboard

CORE20 PLUS 5

The scale of the Suffolk challenge

CORE20:
80,000 residents in Suffolk

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

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

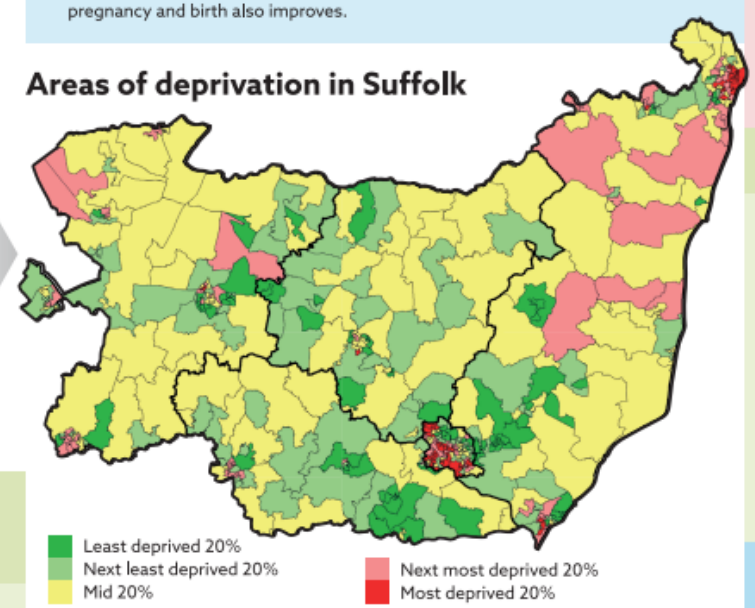
- Hypertension (high blood pressure), is a key priority within the NHS Long Term Plan and a risk factor for hospitalisation or death from heart attack or stroke.
- Although standards are in place that describe good control of hypertension, it is estimated that only four in ten adults nationally with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

Maternity

*where ethnicity was recorded

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

Areas of deprivation in Suffolk



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

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

Respiratory disease

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

Smoking: 83,000- 109,000 current smokers

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

Severe mental illness: 1,500 missing health checks

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

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

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

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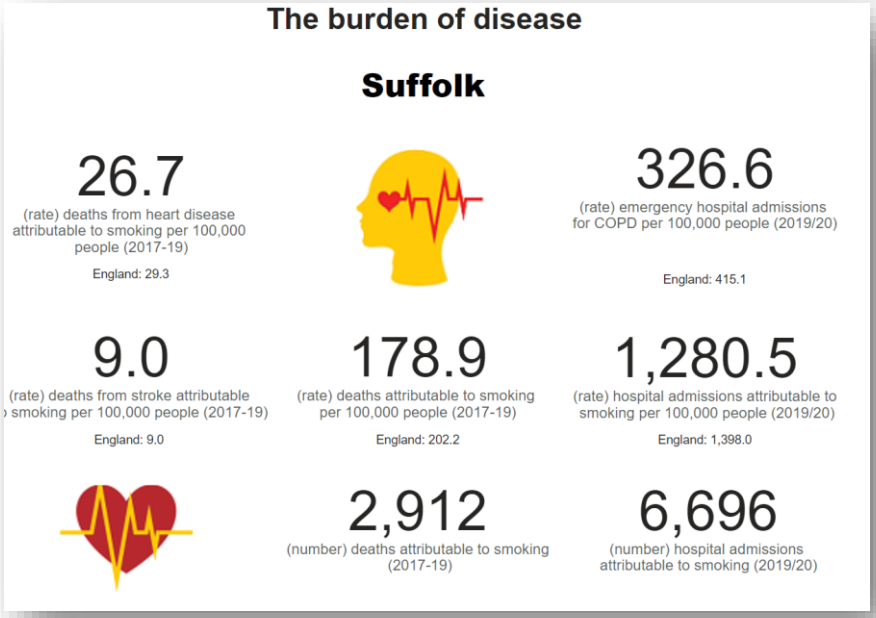
Smoking – why does it matter

- Smoking is the biggest cause of preventable death in England, with the Global Burden of Disease study ranking tobacco as the top modifiable risk factor driving deaths and disability. 96,000 deaths were attributable to smoking in England in 2019.
- In Suffolk, smoking-related illnesses cause around 1,000 deaths every year, which equates to almost three people dying every day in the county.
- Just as the links between smoking and poor health are irrefutable, there are proven short and medium term benefits of stopping smoking. Within three months of quitting, blood circulation improves and lung function increases.
- After a year, the risk of coronary heart disease has halved compared with a person who continues smoking. Five years after quitting, the risk of developing many cancers has halved and the risk of cervical cancer and stroke fall to that of a non-smoker.
- 2020/21 data indicates that 1,786 (52%) of smokers quit in Suffolk (at 4 weeks)– we need to increase those numbers to ensure more people benefit from stopping smoking.

Source: OHID Tobacco Dashboard, NHS, Fingertips, WHO

Smoking –the Suffolk picture

- Smoking prevalence is decreasing both locally and nationally. However, too many people still smoke.
- In 2020/21, 1 in 7 (13.7%) Suffolk residents aged 18+ were smokers, ***over 83,000 people***, some estimates (such as the Quality and Outcomes Framework) ***estimate this to be higher- at 109,000 people in Suffolk.***
- Smoking while pregnant can cause a range of problems for the baby. In 2020/21, 1 in 14 (7.5%) of Suffolk mothers smoked at the time of delivery, with higher rates in East Suffolk. Although this rate has decreased over the last decade, it still represents ***over 450 Suffolk mothers smoking while pregnant each year***.
- Smoking prevalence is higher among some groups, such as routine and manual workers and people who rent their homes from the local authority, where rates of smoking are almost double that of the Suffolk population as a whole; people living in areas of higher deprivation and people with mental ill health. In Suffolk:
  - Current smokers in routine and manual occupations: **24.7%**
  - People who rent from local authority or housing association: **36.9%**
  - Smoking prevalence in adults with a long term mental health condition (18+): **20.5%**



View more data like this on the OHID tobacco dashboard!

Source: Fingertips and OHID tobacco dashboard

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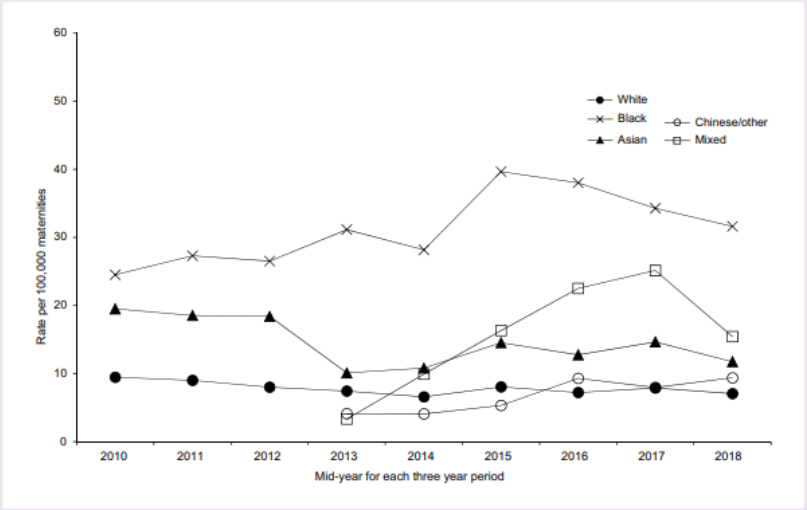
Continuity of carer for women during pregnancy, birth and postnatal care: why does it matter?

The **continuity of carer model** is a way of delivering maternity care so that women receive dedicated support from the same midwifery team throughout their pregnancy.

Figure 2.7: Maternal mortality rates 2009-19 among women from different ethnic groups in England*



*Data for England only due to availability of denominator data

- The NHS Long Term Plan and the MBRRACE-UK reports highlight the significant differences in maternal mortality between different ethnic groups and those from the most deprived areas.
- Black and Asian mothers are more likely to die as a result of childbirth than their white counterparts and this gap has widened since 2010.
- Evidence suggests that mothers who receive continuity of carer are less likely to lose their baby or experience preterm birth. Their experience of care during pregnancy and birth also improves.
- Ensuring continuity of carer for 75% of Black, Asian and Mixed ethnicity women and those living in deprived areas by 2024 will help to meet the government's national maternity safety strategy ambition, which includes halving rates of stillbirths, neonatal deaths and reducing the rate of preterm births from 8% to 6% by 2025.

Source: NHS, MBRRACE-UK (Chart) and NHS Evidence for the priority areas

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Continuity of care for women during pregnancy, birth and the postnatal stage: the Suffolk picture

- Robust local data for continuity of care during pregnancy broken down by ethnic group is not currently available at a local level. In the future, there should be data in the **Healthcare Inequalities Improvement Dashboard,** but this data has not yet been published.

- Data from the NHS Maternity Services Dashboard indicated that in 2021 the following percentages of women reported continuity of carer:
  - East Suffolk and North East Essex - 9.9%
  - West Suffolk – 13.5%
  - Data not available for James Paget
  - The national target was – 11.5%
  - This data shows more needs to be done generally to improve continuity of care during pregnancy, even before looking at inequalities in relation to ethnicity.

- The SNEE maternity services note that continuity of care during pregnancy is not currently rolled out. Commencement is based upon a critical number of qualified midwives being recruited, to enable the recommended ratio of midwives to numbers of pregnant woman which is critical to achieving the desired clinical outcomes.

- Healthwatch Suffolk collate findings in relation to parents experiences of maternity services, but this doesn't include continuity of care during pregnancy ethnicity data.

- Experimental maternity statistics produced by the NHS indicate that in the year to April 2022 in Suffolk:

Ethnicity of mother	Number of births in year	% of all births for year
White	6,200	77.0%
Black or Black British	215	2.7%
Asian or Asian British	345	4.3%
Mixed ethnic group	215	2.7%
Other ethnic group	195	2.4%
Not known/ recorded	885	10.9%

Where ethnicity data had been recorded, 12.1% of births in the year to April 2022, were to mothers from non-White ethnic groups. Ipswich and West Suffolk have the highest numbers of births to mothers from ethnic minority groups.

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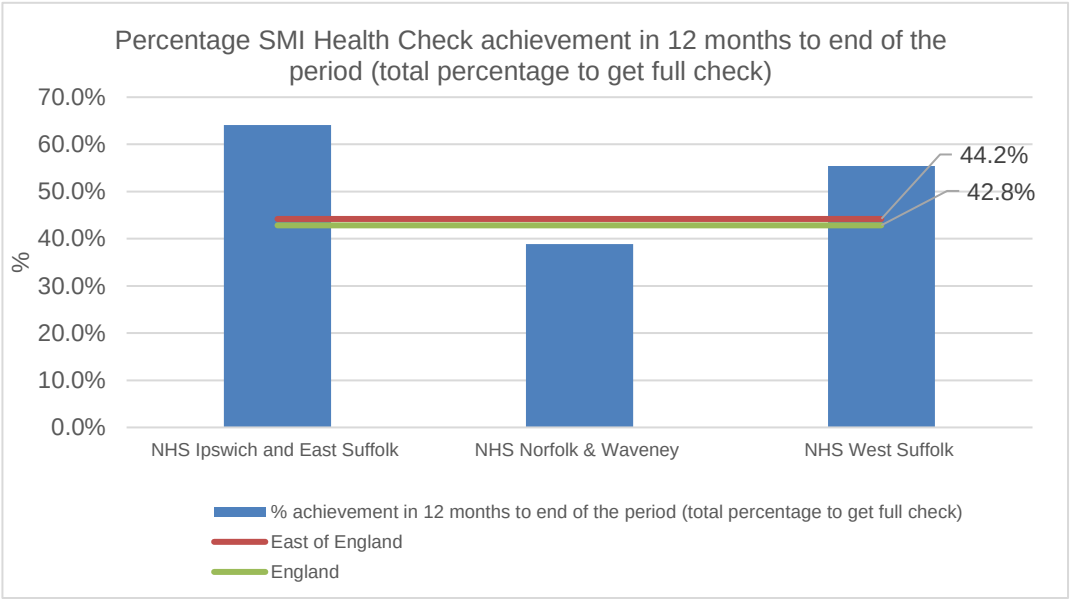
Ensuring annual health checks for 60% of those living with severe mental ill-health (SMI): why does it matter?

- People with a mental illness such as schizophrenia or bipolar disorder die on average 15-20 years sooner than the general population. The prevalence of Severe Mental Illness (SMI) within the most deprived areas is triple that of those living in the least deprived areas.
- SMI is also more common in Black-British people – 71% of psychosis diagnosis in the UK are among this group.
- It is easy to assume that the shorter life expectancy in those experiencing SMI is due to the impact of suicide, however this is not the case. Much of this reduced life expectancy is from higher rates of physical health conditions, such as cardiovascular disease.
- Young adults with SMI are more likely to be overweight and experience physical health conditions including obesity, hypertension and diabetes which are linked with premature mortality.
- Annual health checks for people with SMI support the early detection of physical health conditions and help to improve access to evidence-based physical care, assessment and intervention.
- There is evidence to suggest that addressing unhealthy behaviours, suboptimal use of healthcare resources, and poor life circumstances have the potential prolong life expectancy at birth by four and six years for those experiencing SMI.

Sources: NHS Evidence for the priority areas, NHS Blog – Achieving more for people with SMI, Potential gains in life expectancy from reducing amenable mortality among people diagnosed with serious mental illness in the United Kingdom

The health check gap for those with severe and mental ill-health: the Suffolk picture

- The latest data for the CCG areas covering Suffolk indicates significant variation in the percentage of annual health checks delivered for people with SMI.
- Only 38.9% of people in Norfolk and Waveney had had a health check, increasing to 64.1% in Ipswich and East Suffolk.
- **If everyone in this group were to receive their health check, a further 1,500 health checks would need to be completed each year for Ipswich and East Suffolk, and West Suffolk, rising to 7,000 if Norfolk and Waveney is included.**



Source: Physical Health Checks for people with Severe Mental Illness (Q4 2021-22)

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Preventing and managing chronic respiratory disease: why does it matter?

- Chronic respiratory disease is the third biggest cause of the life-expectancy gap between the most and least deprived groups.

- 2020 data indicates that the rate of premature mortality due to respiratory disease among people living in the most deprived quintile of areas was a least twice the average for England.

- Acute exacerbations of chronic obstructive pulmonary disease account for roughly 1 in 8 emergency hospital admissions in England and deprivation is linked with increased emergency health care use among people with COPD.

- In Suffolk, emergency COPD admissions have been consistently statistically significantly lower compared to England since 2010/11. The latest data for 2019/20 indicates 1,755 admissions equating to a rate of 327 per 100,000 (England 415 per 100,000).

- The NHS Long Term Plan respiratory programme aims to improve diagnosis, treatment and pulmonary rehabilitation with the **Core20PLUS5** approach focusing on accelerating flu, COVID-19 and pneumonia vaccine uptake. This will help to minimise emergency admission winter pressures arising from COPD exacerbation and reduce avoidable deaths.

Source: NHS Evidence for the priority areas, Fingertips

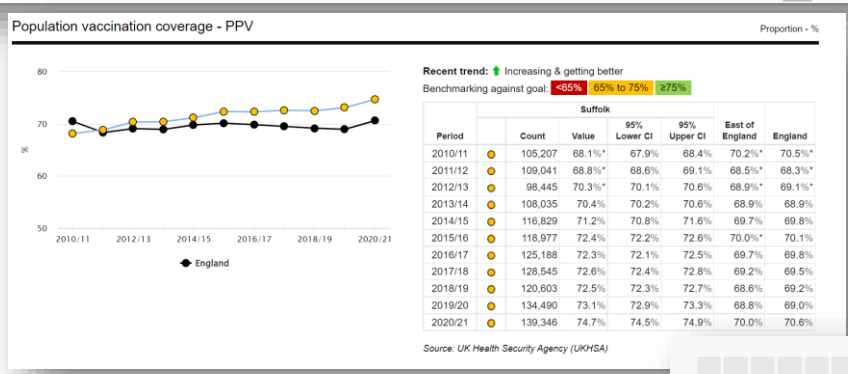
Preventing and managing chronic respiratory disease – the Suffolk picture

- 2020/21 and 2022 data for flu vaccination coverage shows that Suffolk exceeds national targets, however there is room to improve coverage further.
- An estimated **26,000 people aged 65 and over** in Suffolk who were eligible for a flu vaccination in 2021/22 did not receive one. As well as **42,000 missed flu jabs** for under 65's in at risk groups 2021/22.
- There are also inequalities in uptake, with lower uptake in more deprived areas and in certain ethnic groups.
- COVID-19 vaccination uptake is high in Suffolk, with over 4 in 5 of the eligible population receiving a 1st and 2nd dose of the vaccine as of July 2022.
- However there are still people unvaccinated, with **139,000 COVID-19 missed vaccines** based on Aug 2022 NIMS data.
- There were also **47,000** Pneumococcal missed vaccines in 2020/21.

Vaccination uptake – Influenza Vaccine Uptake Monitoring Programme - from 1 September 2021 to 28th February 2022 for healthcare workers and GP patients. From 1 September 2021 to 31 January 2022 for school children

Show 10 entries Search:

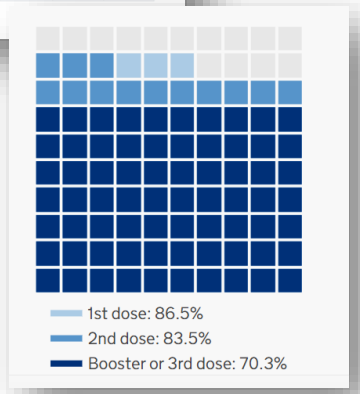
LA	GP Patients						School Children		
	65 and over	Under 65 (at-risk only)	Pregnant	50 to under 65 years and NOT in a clinical risk group	All 2 year olds (combined)	All 3 year olds (combined)	All primary school age (age 4 to 11 years old)	All secondary school age (age 11 to 16 years old)	All school age children (age 4 to 16 years old)
Suffolk	85.9%	59.5%	44.1%	51.3%	60.3%	61.3%	70.2%	55.7%	64.1%
England	82.3%	52.9%	37.9%	45.7%	48.7%	51.4%	57.2%	43.3%	51.5%
East of England	83.3%	55%	37.6%	46.7%	52.4%	55.1%	63.0%	47.0%	56.4%



Period		Suffolk Count	Value	95% Lower CI	95% Upper CI	East of England	England
2010/11		105,207	68.1%*	67.9%	68.4%	70.2%*	70.5%*
2011/12		109,041	68.8%*	68.6%	69.1%	68.5%*	68.3%*
2012/13		98,445	70.3%*	70.1%	70.6%	68.9%*	69.1%*
2013/14		108,035	70.4%	70.2%	70.6%	68.9%	68.9%
2014/15		116,829	71.2%	70.8%	71.6%	69.7%	69.8%
2015/16		118,977	72.4%	72.2%	72.6%	70.0%*	70.1%
2016/17		125,188	72.3%	72.1%	72.5%	69.7%	69.8%
2017/18		128,545	72.6%	72.4%	72.8%	69.2%	69.5%
2018/19		120,603	72.5%	72.3%	72.7%	68.6%	69.2%
2019/20		134,490	73.1%	72.9%	73.3%	68.8%	69.0%
2020/21		139,346	74.7%	74.5%	74.9%	70.0%	70.6%

Source: UK Health Security Agency (UKHSA)

COVID-19 vaccination uptake :



Source: Suffolk flu reporting and Health Protection Team, Flu vaccine uptake report, Fingertips, GOV.UK

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

- Cancer is one of the biggest contributors to inequalities in life expectancy. People from the most deprived communities more likely to get cancer, be diagnosed at a late stage for certain types of cancer and to die from the disease.
- National data indicates that 59.3% of people in the least deprived decile have their cancers diagnosed at stage 1 or 2, compared to only 53.5% of people in the most deprived decile.
- Early presentation, referral, screening and diagnosis are key to addressing this and the Long Term Plan sets out an ambition for 75% of cancers to be diagnosed at stage 1 or 2 by 2028.
- Local and national interventions to drive early diagnosis have the opportunity to help address this. For example, a targeted lung health check programme is currently being piloted in the most disadvantaged areas of the country where rates of mortality from lung cancer are high.

Source: NHS Evidence for the priority areas

Early cancer diagnosis: the Suffolk picture

- The latest staging data for Suffolk is from 2019 (pre-pandemic).
- This shows that whilst overall Suffolk has a statistically significantly higher percentage of cancers diagnosed at stage 1 or 2 than the England average, at 58.3%, there is variation within the county. Rates in East Suffolk (56.6%) and Ipswich (55.4%) are lower than in other parts of the county.
- There is also a significant gap between the 58.3% currently diagnosed at stage 1 or 2 in Suffolk and the CORE20PLUS5 ambition of 75%. Achieving this would require a further 650 cancers to be diagnosed at stage 1 or 2.
- When looking at nationally available data on cancer staging and deprivation, a lower proportion of people are diagnosed with cancer at an early stage in more deprived areas compared to less deprived areas (53.1% in the most deprived decile compared to 59.3% in the least deprived decile).

Source: Fingertips

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Hypertension case-finding and optimal management and lipid optimal management: why does it matter?

- Hypertension (high blood pressure), is a key priority within the NHS Long Term Plan and a risk factor for hospitalisation or death from heart attack or stroke.
- Having high blood pressure or atrial fibrillation are both key risk factors for suffering a heart attack or stroke. So while high blood pressure and atrial fibrillation are not usually a direct reason for being admitted to hospital or dying, they may lead to an increased likelihood of serious complications.
- Aside from being one of the main causes of mortality and morbidity in the UK, cardiovascular disease is also closely associated with health inequalities. Risk factors associated with cardiovascular disease such as smoking, physical inactivity, poor diet and obesity are more common in more deprived areas.
- In 2016-18, around one in five avoidable deaths from cardiovascular disease in people under the age of 75 were among people in the most deprived decile of communities in England. Research suggests that the incidence of high blood pressure within the most deprived communities is roughly double that of the most affluent areas and people living in the most deprived areas are nearly twice as likely to have a stroke.
- The British Heart Foundation has a helpful visualisation which shows the correlation between heart and circulatory disease death and deprivation.
- Although standards are in place that describe good control of hypertension, it is estimated that only four in ten adults nationally with high blood pressure are both aware of their condition and are managing it properly.
- Finding people with hypertension allows early intervention to optimise blood pressure and reduce the risk of heart attacks and stroke. It also presents an opportunity to offer preventative measures to those at risk of developing the condition.

Source: NHS Evidence for the priority areas, State of Suffolk

Hypertension case finding: the Suffolk picture

- Figures about diagnoses of high blood pressure are likely to underestimate the true number of people with high blood pressure in Suffolk. This is because a certain number of people will be living with the condition but have not been formally diagnosed.
- Latest aggregated GP data for Suffolk indicates around 127,600 people have high blood pressure (15.8%).
- Based on prevalence estimates developed by Public Health England, between 11.8-13.5% of individuals aged 16 and over in Suffolk have undiagnosed hypertension. Applying these estimates to the Suffolk population would suggest that there are between 74,000-84,000 Suffolk residents aged 16 and over with undiagnosed hypertension.
- Once diagnosed it is also important that hypertension is effectively managed. Using GP data aggregated to Suffolk, only 55.9% of hypertensive patients under 80 had a blood pressure reading that was 140/90 mmHg or below, equating to approximately 10,700 people. This means that 8,500 people could have their blood pressure more effectively managed.

GP recorded diagnoses of hypertension among individuals of all ages, CCGs, East of England, England, 2020/21

High Blood Pressure Prevalence

Area Name	%	Number	Denominator
England	13.9	8,457,600	60,716,244
Suffolk GPs (aggregated)	15.8	127,647	807,520

People aged under 80 with a diagnosis of high blood pressure whose last blood pressure reading was 140/90 mmHg or below (Denominator includes PCA adjustment)

Area Name	%	Count	Denominator	Missed optimisation
England	54.9	707,619	1,289,065	581,446
Suffolk GPs (aggregated)	55.9	10,727	19,198	8,471

Source: Fingertips

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The 'PLUS' populations for Suffolk

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

- PLUS populations can be defined at different levels – this report suggests PLUS populations for Suffolk as a whole; but Alliances and Integrated Neighbourhood Teams will also want to define their local PLUS populations over time, ideally using linked data from population health management, coupled with input from local communities and the knowledge the teams have of their local areas.

PLUS Populations for Suffolk

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

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What does the current data tell us about who Suffolk's overall 'PLUS' populations should be?

Population	Outcomes	Experience	Access
Ethnic communities in Suffolk	• Without regular access to holistic data including ethnicity, it is difficult to be certain about local outcomes – but the evidence base suggests they are highly likely to be worse: - People from ethnic minority groups are more likely than White British people to report limiting long-term illness and poor health. - The risk of developing diabetes is up to **six times higher** in South Asian groups than in white groups and South Asian groups have higher mortality from diabetes. - Compared with the White British group, disability-free life expectancy is estimated to be higher among the Other White, Chinese and Black African groups, lower among Black Caribbean, Other Black, Indian, Other Asian and some Mixed groups, and lowest among the Pakistani and Bangladeshi groups. - Compared with the White group, the rate of women dying in the UK in 2016–18 during or up to one year after pregnancy is more than **four times** higher in the Black group, and almost double in the Asian group (although the number of such deaths is relatively low). • The most reliable population data on ethnicity currently dates from the 2011 Census – significant changes are likely to have occurred since then but as we don't know about them, we are unlikely to have planned for them in an optimal way. • Refugee populations in Suffolk are growing and have very specific and complex needs which need to be met.	• The Suffolk and North East Essex (SNEE) ICS Thinking Differently Together event highlighted the experiences of minority ethnic communities, and staff in health and care • The 'What Are We Missing?' virtual event, jointly organised by Healthwatch Suffolk, Ipswich and Suffolk Council for Racial Equality (ISCRE) and Ipswich and East Suffolk Clinical Commissioning Group, brought people together to talk about their experiences and to discuss the issue of inequalities and injustices within health and social care. • The My Health Our Future Healthwatch Suffolk survey explored experiences of ethnic minority school age populations in their focused report. • Recent survey findings published via the BMJ indicate two thirds (65%) of Black respondents said that they had experienced prejudice from doctors and other staff in healthcare settings. This rose to three quarters (75%) among Black people aged 18 to 34.	• Late diagnoses of HIV infection are statistically worse in Black-African people 50.1% vs 40.6% for White • National research has identified wide ethnic inequalities in perceived support from local services for management of long-term conditions across almost all minority ethnic groups, as well as poor experience of primary care. • National research indicates Black groups have lower than expected rates of access to and use of cardiovascular care • Internal research by Suffolk's Public Health team during COVID-19 found 'hidden' cohorts who may have specific health access needs in Suffolk (in relation to vaccine access – but this could extend more generally). Seasonal or migrant agribusiness workers are an example. • Refugees and asylum seekers (status dependent) have different access rights to NHS services, for example Ukrainian refugees and refused asylum seekers.
Coastal Communities in Suffolk	• The Chief Medical Officers National Annual Report 2021 highlighted that coastal communities have some of the worst health outcomes in England, with low life expectancy and high rates of many major diseases. • The specific health challenges of coastal communities often have much more in common with one another than their nearest inland neighbours. • Risk factors, including smoking, are higher, with analysis suggesting an excess smoking rate in coastal communities of 6.7% compared to England. • Coastal communities often have a higher proportion of elderly residents than the general population, and this is set to increase over the following decades. • Research has indicated that coastal areas have also been subject to cultural and social displacement, with traditional economic, socio-cultural and political connections being severed for many coastal residents. This displacement is a risk factor for chronic psychological distress and in turn health inequality.	• Lowestoft Rising and Felixstowe Forward are locally established collectives to working collaboratively to improve their local areas. • A snap survey in the Lowestoft Journal in 2022 noted some respondents were ignoring their health conditions or concerns after failing to get an appointment with their GP in the Waveney area.	• There is evidence of a significant health service deficit in terms of recorded service standards, cancer indicators and emergency admissions in coastal communities. The reasons for this are unclear, however possible explanations include challenges with the retention of medical workforce and access to services. Health Education England Analysis found that despite coastal communities having an older and more deprived population, they have 14.6% fewer postgraduate medical trainees, 15% fewer consultants and 7.4% fewer nurses per patient.

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The Tackling inequalities in healthcare access, experience, and outcomes NHS resource aims to support NHS systems in reducing healthcare inequalities and compliments the Healthcare Inequalities Improvement Dashboard and Actionable Insights tool.

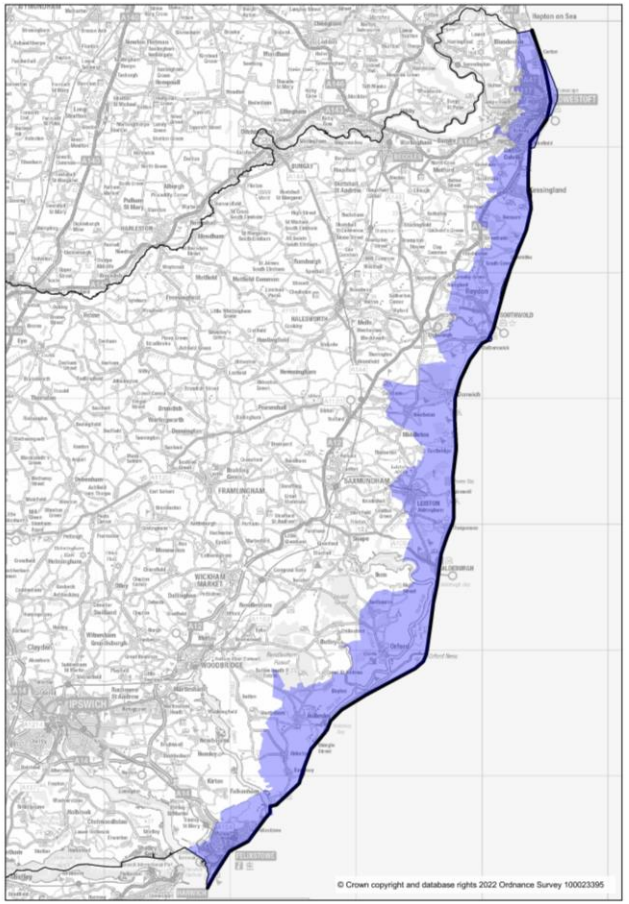
What does the current data tell us about who Suffolk's overall 'PLUS' populations should be?

Population	Outcomes	Experience	Access
Rural communities in Suffolk	• Many people who live rurally in Suffolk have relatively good health outcomes, and are less deprived than our urban populations. However, that is not true for everyone, and more deprived rural areas with high needs may be more difficult to identify • National research indicates rural areas are disproportionately affected by 'diseases of despair' (including alcohol misuse and self-harm). • Rural homelessness is also being exacerbated by cost of living pressures. • Older people living in more rural parts of Suffolk could also experience higher levels of loneliness and/or social isolation. **Age UK** have produced interactive maps detailing the relative risk of loneliness that are broken down into small areas of Suffolk. • Suffolk's rural population is older than its urban population, and the proportion of older people in Suffolk's rural population is increasing faster than the proportion of older people in urban areas. Older people are more likely to experience multiple long term conditions compared to younger populations.	• The national State of Rural Services reports survey rural residents to look at service provision – especially in light of the pandemic. Although remote consultation enabled GPs and nurses to communicate with patients, a variety of issues arose including technical and IT or connectivity issues. There were also medical concerns about missed diagnoses among patients with long-term conditions, prescribing to patients at a distance and managing complex cases such as mental ill-health. • CPRE have conducted a 2021 survey examining the experiences of young people living in rural areas in England. Key concerns raised included: affordability of housing, poor digital connectivity, infrequent transport and loneliness.	• Some of the challenges facing rural populations include lack of access to services, high travel costs, and limited public transport options. • Many people in Suffolk who live in rural areas may struggle to access services, particularly if they cannot drive. This is shown in the Indices of Deprivation (IOD) barriers to housing and services data. • The increases in the cost of living may have a particular impact in rural areas of Suffolk, with 28.7% of properties off the gas grid (compared to 14.3% for England), and petrol price currently (Oct 2022) 22.4% higher than the previous year. Rural areas face 'dual energy vulnerability' of higher household and transport energy poverty, and lower wages • Rural health technology develops at a slower pace than in towns and cities
People and groups facing the sharpest health inequalities in Suffolk	There are several groups (sometimes known in Suffolk as groups at risk of disadvantage) that face some of the very sharpest health inequalities in our society. These groups have the worst outcomes as a result including: • The mean age of death for homeless people is 44 years of age compared to approximately 80 years in the general population. • Gypsy Roma and Traveller people have the worst outcomes of any ethnic group across a huge range of areas, including education, health, employment, criminal justice and hate crime. -Surveying Suffolk young people aged 11-19 found that Gypsy, Traveller or Irish Traveller young people were more likely to report having an additional need. 52% had an additional need compared to 32% of their peers. • Asylum seekers are five times more likely to have mental health needs compared to the general population • People with Serious Mental Illness (SMI) are at a greater risk of poor physical health and have a higher premature mortality than the general population. People with SMI die on average 15 to 20 years earlier than the general population. • People in the UK who identify as lesbian, gay, bisexual or transgender (LGBT), experience higher rates of poor mental ill-health and lower wellbeing than those who do not identify as LGBT. The King's Fund note a range of poorer health outcomes for Trans people.	• Healthwatch Suffolk explored experiences of GRT school age populations in their focused report. Gypsy, Traveller or Irish Traveller young people had lower average wellbeing scores than their non-traveller peers and were more likely to report having an additional need. • Community videos highlight experiences from residents about inequalities and experiences in Suffolk. • The 2017 National LGBT survey, found that LGBTQ+ felt their specific needs were not being met, had poorer experience and had major concerns about accessing healthcare • Healthwatch Suffolk have shared experiences of health and care services for LGBTQ+ people. For example a need for more awareness about the issues faced by LGBTQ*+ people when accessing their GP practice. • The King's Fund note trans people experience inappropriate curiosity when accessing services (survey findings).	• Accessing primary and secondary health services remains a frequently cited issue facing Gypsy, Roma and Traveller people, and chronic exclusion across wider determinants of health persists. • People experiencing SMI may experience difficulties in accessing treatment; for example, lack of intervention following conditions being diagnosded • The 2017 National LGBT survey, found at least 16% of survey respondents who accessed or tried to access public health services had a negative experience because of their sexual orientation, and at least 38% had a negative experience because of their gender identity. 51% of survey respondents who accessed or tried to access mental health services said they had to wait too long. 80% of trans respondents who accessed or tried to access gender identity clinics said it was not easy. • Healthwatch Suffolk research notes that access to appropriate care that is specific to the needs of LGBTQ+ people is an issue and there is variation between services.

Why include coastal communities as PLUS communities in Suffolk?

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

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

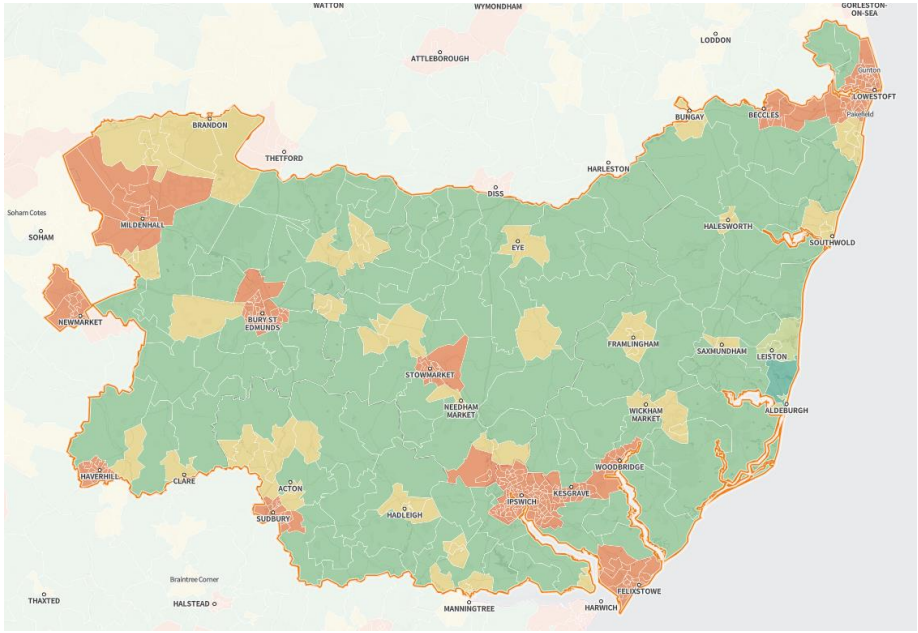


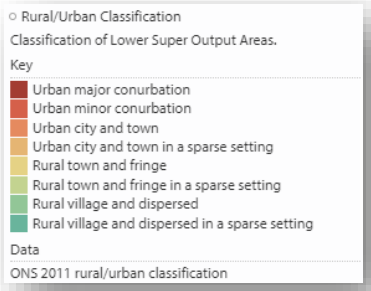
- Office for National Statistics (ONS) analysis found that 71% of coastal towns had both slower population and employment growth than the England and Wales average over the 2009 to 2018 period; this compares with 47% of non-coastal towns.
- The same analysis found that 30% of the resident population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

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

Why include rural communities as PLUS communities in Suffolk?

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





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

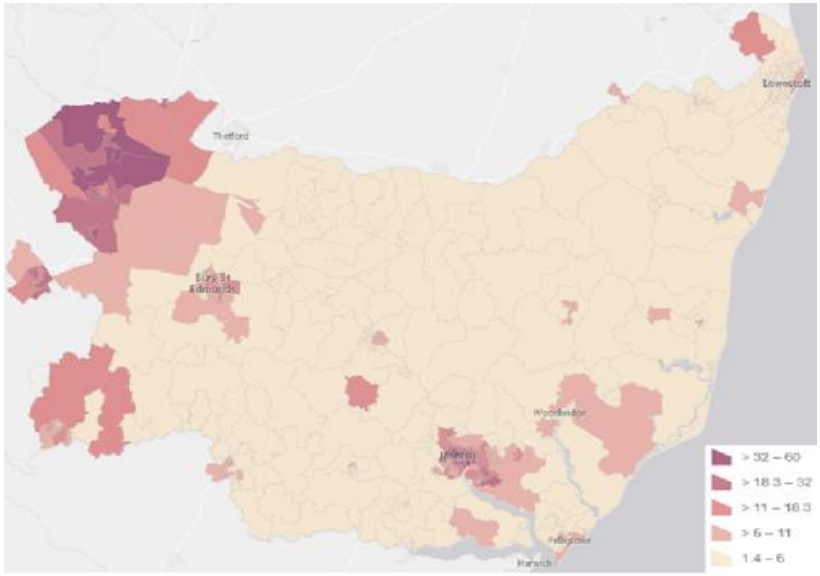
Why include people from minority ethnic communities as PLUS communities in Suffolk?

- At the time of the 2011 Census, 90.8% of Suffolk's population was White British, compared to 79.8% for England. After White British, the most common ethnicities were Other White (4.4%), Asian (1.8%) and Mixed heritage (1.7%). Comparing the data to the 2001 census indicates that diversity is increasing in Suffolk. We are awaiting the 2021 census data.

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

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

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



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

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

Source: State of Suffolk, Local Government Association,

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

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

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

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

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

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

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

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Summary

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