

A Joint Health and Wellbeing Strategy for Suffolk



A Ten Year strategy 2012-2022:
Early priorities for review 2015

May 2013

Foreword

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Chairman of the Shadow Health and Wellbeing Board. Leader of Suffolk County Council

Many things influence our health and wellbeing including the lifestyle we lead, the environment we live in and the health and care services which support us.

The health and wellbeing of people in Suffolk is generally good, but some groups and communities experience poorer health than others. This strategy aims to help everyone in the county improve their health and wellbeing, but with a particular focus on those who experience a poorer quality of life.

Improving the quality of life is also a focus of this strategy and it recognises the importance of high quality care at all stages for example for children with mental health problems, those living with dementia and those reaching the end of their life.

This strategy has been agreed by the new Suffolk Health and Wellbeing Board whose role is to help local people improve their health and wellbeing and reduce health inequalities. The initial draft strategy was agreed by the Board in June 2012 and has been shaped by a range of organisations in a variety of ways including an on-line comment board and an event held in September 2012.

The aim is not to cover everything that affects health and wellbeing. Instead, the focus is on four areas jointly agreed as priorities for the first three years of the 10 year-strategy. The priorities will be used to provide focus for plans across health, local authorities and other relevant organisations to make sure we work together as efficiently and effectively as possible, spending public money in a better way.

The Board recognises the huge role that local people, communities and neighbourhoods play in contributing to improved health and wellbeing within Suffolk. We hope that everyone can identify with the priorities within this strategy and are inspired to take local action to contribute to the strategy's aims.

We are happy to hear your views about this strategy for us to consider when updating it in 2015. If you want to comment then please write to Tessa Lindfield, the Director of Public Health, Suffolk County Council, Endeavour House, 8 Russell Road, Ipswich, Suffolk IP1 2BX.

Vision

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

What is health and wellbeing?

Health and wellbeing encompasses a person's life experience and includes a sense of physical, mental and social wellbeing. Many factors contribute to a person's wellbeing for example how safe they feel in their community and whether they are able to find a job. Through working jointly across health, local government and wider communities we can make a real difference in improving the health and wellbeing opportunities for all those in Suffolk.

Making a difference

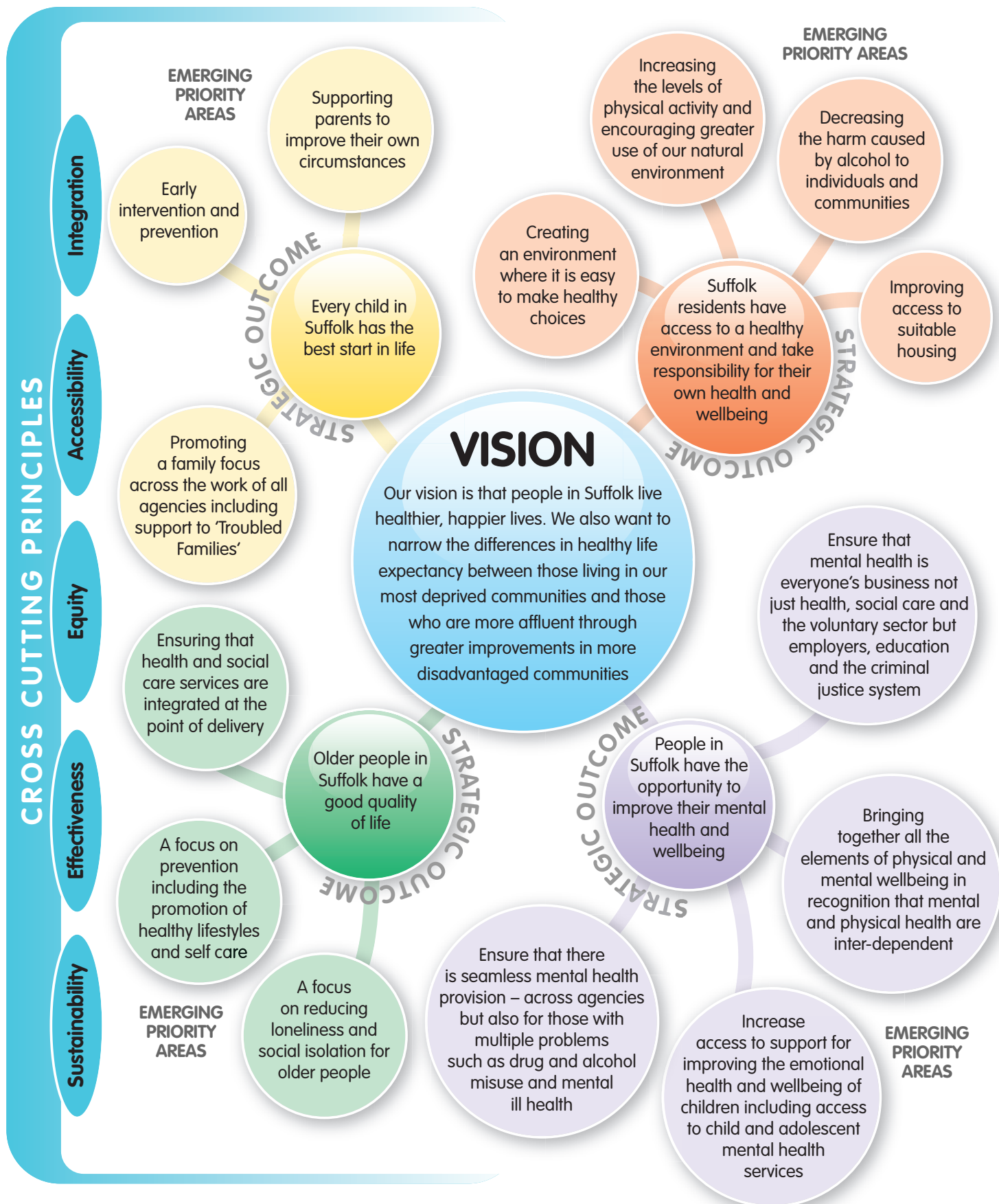
The Health and Social Care Act 2012 requires Suffolk to establish a Health and Wellbeing Board by 2013. The Suffolk Health and Wellbeing Board aims to work differently to enable it to improve the health and wellbeing of those living in Suffolk. It will do this by promoting joint commissioning and influencing the commissioning plans of the broader public services family. By working together and spending public money in a better way the Board will improve health and wellbeing.

While public agencies have a large part to play through the delivery of statutory services, voluntary and community groups have an equally vital contribution to make. They deliver a wide range of services and provide opportunities for people to socialize and feel part of a community at a local level which helps to foster wellbeing within those communities.

This strategy aims to provide a focus for everyone whose work contributes to health and wellbeing, and to use existing countywide and local groups to deliver the outcomes wherever possible.

The overarching aims and priorities of this strategy are shown in the diagram on page 4.





EXAMPLES OF KEY SUPPORTING DOCUMENTS

Local Housing Strategies	VCS Compact	Greenest County	NHS Service Improvement Plans	Police and Crime Strategy	Domestic Violence Strategy	Alcohol Strategy
Suffolk Older People's Charter	Community Safety Strategy	Safeguarding	Suffolk Most Active County	Transforming Suffolk	Children's Plan	Suffolk Ageing Well

Health and Wellbeing in Suffolk

Suffolk is predominantly rural, with a population of 728,163 (2011 census) living across an area of 1467 square miles. The county has an aging population with almost 1 in 5 people (19.9%) aged over 65 years, which is higher than the England average (16.3%). The Suffolk population is expected to increase by 15% over the next 20 years, with the proportion of over 65s increasing by 56%. Ninety percent of the Suffolk population consider themselves to be white British which is higher than the national average of 83%.

The Suffolk population experiences some of the highest life expectancy in England, with a girl born today expected to live 84 years and a boy 80 years. Over the past 10 years life expectancy in Suffolk has increased year on year for both males and females. Whilst this is good news we also need to focus on quality of life and minimise the impact of long term illnesses and disability.

In Suffolk 77% of people report their overall health as good and the county is regarded as a good place to live with a high quality of life. The Halifax Quality of Life Survey in 2009 found residents of Mid Suffolk to have the best quality of life of any rural area in Great Britain. However life expectancy at birth differs greatly between different communities and in Rougham Ward, Bury St Edmunds is 87.9 years, 12 years longer than the 75.9 years for those in the deprived ward of Kirkley, Lowestoft. There are areas of deprivation in all the districts of Suffolk which can be very local and hidden within more affluent communities.

The key issues for Suffolk, highlighted in the Joint Strategic Needs Assessment, are that:

- 1 in 6 children live in relative poverty
- Educational attainment is below national rates
- Suffolk has a low wage economy although employment rates are higher than average
- General affluence masks pockets of deprivation and inequality gaps
- The comparative risk of dying prematurely has increased if you are from deprived areas of Suffolk
- Suffolk has an ageing population

Our children have different life experiences depending on where they live. In Harbour Ward (Lowestoft), 39% of children live in poverty, compared to 5% in Kesgrave East. In Whitton Ward (Ipswich) 27% of children achieved 5 A* to C grades at GCSE compared to 72% in Moreton Hall (Bury St Edmunds). As well as differences within Suffolk our educational attainment is not as good as other areas of England. Less children come to school ready to learn (52% compared to the national average of 59%) and this difference continues to key stage 4 where 52% reach the expected level compared to the national average of 55%. Higher levels of educational attainment lead to more opportunities and improved health and wellbeing and we know that inequalities grow through the lifecycle of a population.

Our health is affected by a large number of factors, from socio-economic, cultural and environmental circumstances to a person's genetic makeup. Economic disadvantage affects health and wellbeing throughout our lives. There is a higher level of early death under the age of 75 in deprived areas of Suffolk and the two main causes are cancers (44%) and cardiovascular disease (26%). People from certain ethnic groups are more likely to have ill health for example those from the Asian sub continent have a higher risk of cardiovascular disease. We also know that people in prisons have some of the highest health needs. Highpoint Prison is one of the largest in Europe and the three other prisons include one for young people aged 14 to 18. We must ensure their health needs are met.

More people are being diagnosed with cancer each year, although early death from cancer fell by 34% between 1993 and 2010 due to early detection and improvements in treatment. However early death is 35% higher in the most deprived areas of Suffolk. Many cancers are preventable and 60% of cancers are thought to be due to unhealthy lifestyles such as smoking, alcohol abuse, poor diet, physical inactivity and obesity.

Heart disease (CHD) is the most important contributor to the inequality in life expectancy. The increased risk of dying before the age of 75, if you come from a deprived area of Suffolk, is 40% for men and 70% for women. Early deaths from heart disease have almost halved in the last decade and studies suggest that over half of this is due to favourable changes in lifestyle, with the decreasing levels of smoking estimated to account for 25% of the fall. Medical and surgical interventions are estimated to account for 40-50% of the fall. Lifestyle is a contributor to our health and wellbeing; 1 in 5 adults smoke, 1 in 4 do not participate in any form of physical activity and 1 in 4 are obese. These factors increase the risk of heart disease, cancers and other health problems.

It is not just physical health that affects our health and wellbeing. Improving mental health is essential; one in four people will suffer from a form of mental illness at some point in their lives, and one in six of the population is suffering from a common mental health problem at any one time. In Suffolk around 9,000 people are seen by secondary mental health services each year. There are strong links between social deprivation and mental ill health.

The number and proportion of older people in the Suffolk population will increase over the next 20 years and the oldest age groups are expected to increase most. It is anticipated that the proportion of 80 to 84 years olds will increase by 71%, 85 to 90 year olds will more than double and the proportion of those aged over 90





will increase by 151%. The increases in the older population will mean that many more people will be affected by health problems, particularly dementia and long term conditions such as diabetes, heart failure and chronic lung disease. For example it is estimated that in Suffolk there will be an additional 11,000 people with diabetes and almost 10,000 additional people with dementia by 2031. This will impact on health and social care services, but also on communities as more carers will be needed in addition to extra care housing and adaptations so people can still remain at home if necessary.

Carers play a vital role in our community. Suffolk had 66,109 individuals who identified themselves as family carers in the 2001 census of which 3,414 were young carers in the 5-24 age range. The economic and social benefits this group provide are significant and ensuring that family carers maximise their own health and wellbeing is essential.

Housing and health are inextricably linked. Living in a house which is in good condition, which the occupiers can afford to heat and in an area in which they feel safe and well supported by the local community underpins the wellbeing of individuals and families. There are still housing needs within Suffolk with the highest need for very sheltered and specialist accommodation for the frail elderly and older people with mental health problems including dementia. There are also shortages for people with disabilities and marginalised young people aged 16-25. In addition affordability is a key issue with many local people being priced out of the housing market by rising costs resulting from high demand and low supply.

Poverty also affects housing and in 2009-10 almost 1 in 5 households (18%) experienced fuel poverty, but this rises to almost 1 in 3 in some pockets across the county. Fuel poverty is associated with an increased risk of ill health in people of all ages and a higher risk of death in older people, particularly those who live alone and also have a chronic illness. At the extreme homelessness is associated with severe poverty and associated with poor health and social outcomes. In 2009-10 the rate of statutory homelessness was 1 per 1,000 households in Suffolk but 1.9 per 1,000 in the Borough of Ipswich.

Further information on the health and wellbeing of those in Suffolk is available from the Joint Strategic Needs Assessment at <http://www.suffolkobservatory.info/JSNA.aspx>

There are many opportunities for improving health and wellbeing within Suffolk. The following examples cover a range of issues where the Board, either collectively or as individual members working with their local partners and communities, can improve the health and wellbeing of Suffolk residents:

- Action in the early years of life – where the prospects for shaping lifelong health and prosperity are critical
- Building on the improvement in attainment and skills through learning about what has been effective, so that there is a positive impact on long-term health as well as employment and economic benefits
- Recognising and supporting the valuable contribution that older people are making through their volunteering and caring roles
- Improving access to suitable housing, including addressing fuel poverty
- Raising awareness that some of the most common problems affecting older people, such as falls, are not an inevitable consequence of old age and the risks can be reduced with some simple changes to lifestyle and adaptations to their homes
- Building on the creativity of local communities and the range of social and community networks in the county to identify solutions to local problems
- Building on the inspiration of the 2012 Olympic and Paralympic Games and the ambition to be the most active county to promote healthy active lifestyles.



Health and Wellbeing Priorities for Suffolk

The aim of Suffolk Health and Wellbeing Board is to improve health and wellbeing and decrease inequalities. Through this strategy the Board wants to ensure that those in Suffolk live long, fulfilling and healthy lives and to see a narrowing of the health inequalities between our affluent and poorer areas. We will know that we have been successful by seeing increased healthy life expectancy and a reduction in the differences in life expectancy and healthy life expectancy between communities in Suffolk.

In its shadow form the Board agreed four strategic outcomes based on information from the Joint Strategic Needs Assessment (JSNA) and evidence that shows action in these areas will help us attain our long term aims. The priorities for action within these areas have been developed using the views of organisations and individuals from across Suffolk. The four strategic outcomes are:

- Outcome one:** Every child in Suffolk has the best start in life
- Outcome two:** Suffolk residents have access to a healthy environment and take responsibility for their own health and wellbeing
- Outcome three:** Older people in Suffolk have a good quality of life
- Outcome four:** People in Suffolk have the opportunity to improve their mental health and wellbeing

There is already a great deal of good work occurring throughout Suffolk that will help achieve these priorities. Some of this work is outlined in the case studies in Appendix 1. The Board wants to focus on areas where they can add most by working together to achieve these priorities.

Outcome one: Every child in Suffolk has the best start in life

Why has the Board chosen this as a priority?

Giving every child the best start in life is crucial in establishing a good foundation for future development. Early intervention not only improves the life chances for our children, but also reduces future costs as intervening early, before behaviours become entrenched, is likely to be more effective.

Giving the best start means ensuring the child has the best environment before they are born. Smoking in pregnancy and being very overweight can have negative effects on a child's health. Breast feeding babies gives them an advantage and evidence shows that children who suffer neglect and extreme lack of stimulation in infancy have decreased brain function which can inhibit their capacity to learn and thrive. Interventions in early infancy have been shown to produce better outcomes and can improve educational attainment, economic status and health, including mental health.



There is a strong link between poverty and poor health, educational and social outcomes. For the 1 in 6 Suffolk children who live in poverty this is evident in that compared to their more affluent peers, children from the most deprived areas in Suffolk are:

- 4.5 times more likely to be absent from their lessons
- More likely to be in the lowest 20% achievers at the end of the Early Years Foundation Stage (EYFS) (age 5)
- Performing 63% lower at GCSE level (age 16)
- 34% more likely to be obese
- Three times more likely to be a teenage parent
- Have higher prevalence of mental ill health especially conduct (behavioural) and emotional disorders. This is particularly evident in vulnerable groups like looked after children, children with learning disabilities and difficulties and young offenders

We know that in Suffolk children achieve less than the national average in educational attainment, and although the underperformance is seen in all ability groups for both boys and girls across Suffolk, those in more deprived areas have worse outcomes than those in affluent areas.

There are also 1150 families identified in Suffolk that fall into the Government's definition of a troubled family. These families are usually well known to many different services and also prominent in their neighbourhoods where they are more likely to be involved in crime and antisocial behaviour.

Priorities for action:

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

The issue of child mental health is recognised as an important factor in giving every child the best start. This area of work is covered in outcome four.

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

Why has the Board chosen this as a priority?

We know that a healthy lifestyle will improve the health and wellbeing of the population and that the environment we live in can facilitate this. If green spaces are available and people feel safe they are more likely to take exercise. Increasing the levels of physical activity is recognised as a valuable cross cutting contribution to all four outcomes in this strategy. Exercise is also encouraged by well planned and properly linked walking and cycling routes. Access to leisure, culture and community based activities all play a part in improving the health and wellbeing of individuals and communities. Appropriate housing is also essential to a person's health and wellbeing.

Tobacco is still the greatest health risk and accounts for up to half of the life expectancy gap between deprived communities and the rest of the population. Three people in Suffolk die each day from the effects of smoking. Increasing levels of obesity and excessive drinking of alcohol affect quality of life and are contributing to increasing rates of long term conditions and hospital admissions. Alcohol and drug abuse also detrimentally affect communities, increasing high risk behaviour which can lead to more sexually transmitted infections and unplanned pregnancies, and also increasing levels of antisocial behaviour and crime.

The level of engagement of the population in their own health affects NHS and social care expenditure. A "fully engaged scenario" where individuals make healthy lifestyle choices and where organisations in the wider public and private sector work to improve health, is required for an affordable NHS and social care system in the future.

Priorities for action:

- Creating an environment where it is easy to make healthy choices
- Increasing the levels of physical activity and encouraging greater use of our natural environment
- Decreasing the harm caused by alcohol to individuals and communities
- Improving access to suitable housing

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

Why has the Board chosen this as a priority?

As the population of older people in Suffolk increases we want to ensure they can enjoy a good quality of life. It remains a challenge to create an environment that enables older people to be active, engaged and independent in safe, supportive communities that value their experience and contribution.



We know that people who enter old age healthily have a longer healthy life expectancy, free of disability. In Suffolk we know that on average people are likely to develop a long term illness or disability before they reach 65 and most of this is due to long term conditions such as coronary heart disease, diabetes and cancer and stroke. However, if individuals reach retirement without developing a disability they are estimated to live a further 8.5 years (males) and 9.7 years (females) in good health.

It is widely recognised that as the proportion of older people increases the current way health and social care services are provided is unlikely to be sustainable. Evidence suggests that choosing a healthy lifestyle is likely to reduce demand on health and social care in the long term and evidence based treatment of conditions such as cancer, coronary heart disease, diabetes and stroke can contribute to healthier life expectancy.

Appropriate housing, access to transport and a safe environment can improve quality of life, independence and promote social inclusion. Evidence suggests that social isolation is a contributing factor in over 60% of preventable illness. Voluntary and community groups play a vital role in helping address social isolation across the county. Community-based assessment and support can enable older people to live at home independently and reduce admissions to hospital and nursing homes.

Falls are a leading cause of injury, subsequent illness and also death in older people. There is strong evidence that falls prevention services, such as exercise programmes focusing on improving strength and balance training, are effective and cost-effective and enable older people to remain independent longer. Where individuals do have a high level of need due to ill health evidence shows it is essential that there is coordinated care across the NHS and social care system, both in the community and when people are discharged from hospital. Technology has an important role to play both in helping people remain independent in their own homes and as a means of addressing social isolation. Self care – encouraging people to do practical things to keep themselves healthy - is an important part of ageing well.

Priorities for action

- Ensuring that health and social care services are integrated at the point of delivery
- A focus on prevention including the promotion of healthy lifestyles and self care
- A focus on reducing loneliness and social isolation for older people

4 Outcome four: People in Suffolk have the opportunity to improve their mental health and wellbeing

Why has the Board chosen this as a priority?

Mental ill health affects many people in our community. One in ten children aged between 5 and 16 years has a mental health problem and self harm is not uncommon affecting 1 in 10 aged 15-16. One in 10 new mothers experience postnatal depression and at least one in four people will experience a mental health problem at some point in their life. At any one time one in six adults has a mental health problem and the proportion affected is much higher for those who are in prison. This is important in Suffolk where four prisons are based, one of which is the largest in Europe.

Mental ill health can negatively affect a young person's education and an adult's ability to work. It also affects their wider health and over half of older people in acute hospitals for a physical problem also have a mental health condition.

Mental Illness still has a stigma and is often not recognised. For example it is believed that a quarter of people over the age of 65 living in the community have symptoms of depression serious enough to warrant intervention, but only a third of them discuss it with their GPs, and only half of those get treatment. Research has identified that many vulnerable adults experience complex health and social problems, including mental health issues, and there is evidence of poor mental health as both consequence and cause of inequalities and exclusion.

It has been estimated that for every £1 invested in early identification and treatment for mental health problems up to £7.89 is saved. The majority of these savings sit outside the NHS or social care. Improving the mental health and wellbeing of those in Suffolk will enhance the lives of individuals and families but also increase economic prosperity within Suffolk.

Priorities for action

- Ensure that mental health is everyone's business not just health, social care and the voluntary sector but employers, education, and the criminal justice system
- Increase access to support for improving the emotional health and wellbeing of children including access to child and adolescent mental health services
- Ensure that there is seamless mental health provision – across agencies but also for those with multiple problems such as drug and alcohol misuse and mental ill health
- Bringing together all the elements of physical and mental wellbeing in recognition that mental and physical health are inter-dependent

How will the Board Make a Difference and Deliver its Strategic Aims?

The Board will lead the Suffolk system to improve health and wellbeing and will need to work differently in order to achieve this in the current, challenging, financial climate. The combined budget of the member organisations on the Health and Wellbeing Board is in excess of £1,500 million and expenditure, from maintaining roads and waste management to commissioning hospital services, affects our health and wellbeing. The Board wants to be visible and provide strategic leadership, giving a clear steer on priorities. As well as the significant resources brought to the table by individual Board members they will also have influence and be role models. For example when Suffolk launched its ambition to become England's 'Most Active County' in February 2012 the leader of the County Council (Chairman of the Shadow Board) actively sponsored the initiative. He committed to improve his own fitness level and completed part of the East of England element of the round Britain cycle ride.

The Board has already agreed in its shadow meetings that a major focus will be prevention and early intervention in addition to taking a lifespan approach. As part of taking forward the priority for older people in Suffolk to have a good quality of life it agreed to put greater emphasis on prevention to ensure that people reach old age as healthy as possible. It also supported the implementation of a new integrated approach to health and social care in Suffolk including the establishment of Neighbourhood Partnership Networks (NPNs), multi-agency groups which will provide proactive management of health and social care for older people.

The Board has recognised it needs to deliver a more integrated approach. Our consultation has identified that currently partners are still seen to be working in silos. The Joint Health and Wellbeing Strategy will set the framework to ensure the right things are happening in the right places. For the Waveney area of Suffolk the Great Yarmouth and Waveney System Leadership, Health and Wellbeing Partnership (SLP) is already established and taking responsibility in overseeing a whole system model for the proactive management of health and social care for older people. More robust joint commissioning arrangements between the Ipswich and East Suffolk Clinical Commissioning Group (CCG) and West Suffolk CCG and Suffolk County Council are progressing rapidly. In addition planning is advanced for System Leadership Boards to identify and agree on areas of beneficial joint working, agree plans to deliver joint strategic aims where cross organisational co-operation is required and to scrutinise progress of the joint delivery workstreams and remove blockages to progress.

The work of the Board needs to permeate into communities. Communities contribute greatly to the health and wellbeing of the people of Suffolk and the support and activity within the community can be utilised, encouraged and expanded to meet needs that have been locally identified. This is called an "asset-based approach". It is a different relationship between the public sector, voluntary organisations and communities that the Board wants to adopt. Expanding the asset base of communities, particularly those in the areas of greatest health inequalities, will be an important aspect of delivering this strategy.

The Board will agree an annual action plan for the joint delivery of the priorities highlighted in this strategy. The action plan will identify specific actions and set targets to measure progress on the chosen outcome measures. Each year progress will be reviewed and the next action plan agreed.

Cross-cutting principles

The following principles have been agreed to ensure the best use of resources and that health inequalities are addressed.

• Equity

Provision of services should be proportional to need to avoid increasing health inequalities, and targeted to areas which need them the most.

• Accessibility

Services should be accessible to all, with factors including geography, opening hours and access for people with disabilities or those that find it harder to access services considered.

• Integration

Service provision and care pathways should be integrated, with all relevant providers working together. This will maximise the benefits of delivery through the Health and Wellbeing Board and avoid duplication.

• Effectiveness

Services should be evidence-based and provide value for money.

• Sustainability

Services should be developed and delivered with consideration of environmental and social sustainability.

In addition there are a number of cross-cutting themes which underlie the delivery of the strategy. The Board and its constituent parts will:

- Drive a more proactive approach where preventative measures are put in place to reduce future demand for services;
- Work with other partnerships to identify areas of common action, for example the Safer Suffolk Partnership Board and Local Enterprise Partnership;
- Reflect the aspirations of this Joint Strategy in their own policy frameworks and commissioning, and encourage their partners to do the same;
- Recognise the role that business has to play in the delivery of the strategy, for example in housing and leisure provision and job creation, and work with Suffolk businesses to address these markets;
- Actively promote the health and wellbeing of their own workforces, and encourage Suffolk employers to do the same;
- Encourage the use of technology to help maintain health and wellbeing;
- Use the Health and Wellbeing Board charter to support the delivery of the strategy (see Appendix 2).

How will we monitor the success of this Strategy?

The outcomes measuring the success of this strategy will be reviewed by the Health and Wellbeing Board annually, although for many of the outcomes progress will not be seen immediately. The suggested outcome measures sit within the Public Health, Adult Social Care and NHS Outcomes Frameworks and will therefore not only be able to measure local progress but also how we compare to other areas of England. Some of the outcomes are not currently measured but national work is addressing this. We accept that the measurement of wellbeing is challenging but we are committed to develop local indicators based on best evidence and research to demonstrate progress in Suffolk.

If this strategy is successful, over the next 10 years we will achieve:

- an increase in healthy life expectancy (which takes account of the quality of people's health as well as the length of life)
- a reduction in the differences between communities in life expectancy and healthy life expectancy (through greater improvements in more disadvantaged communities)

The strategic outcomes and priorities identified for action in the first three years of the strategy will be measured by the key indicators set out in the following table.

Strategic Outcomes, Priority Areas and Key Indicators

Strategic outcome	Priority areas	Key measures (Indicators)
Outcome 1 Every child in Suffolk has the best start in life	1.1 Early intervention and prevention	1.1.1 Decreased prevalence of smoking at delivery 1.1.2 Decreased under 18 conception 1.1.3 Increased breast feeding rates 1.1.4 Increased uptake of free early learning for disadvantaged 2yr olds and universal offer for 3 and 4 yr olds 1.1.5 Increased "good level of attainment " at age 5 1.1.6 Increased level of attainment at Key stage 3&4 1.1.7 Decreased prevalence of overweight and obesity in 4-5 yr olds 1.1.8 Decreased prevalence of overweight and obesity in 10-11 yr olds 1.1.9 Decreased tooth decay in children aged five
	1.2 Promoting family focus across the work of agencies including the "Suffolk family focus" initiative	1.2.1 Improved school attendance 1.2.2 Reduced crime and antisocial behaviour 1.2.3 Reduced NEET in 16-18 yr olds 1.2.4 Reduction in reoffending
	1.3 Supporting parents to improve their own circumstances	1.3.1 Increased uptake of evidence based parenting programmes
Outcome 2 Suffolk residents have access to a healthy environment and take responsibility for their health and wellbeing	2.1 Creating an environment where it is easy to make healthy choices and take responsibility for own health	2.1.1 Decreased smoking prevalence in adults > 18 yrs 2.1.2 Increased uptake of NHS health checks in those eligible 2.1.3 Increased detection and treatment of Chlamydia infection (15-24 yr olds) 2.1.4 Increased uptake in cancer screening 2.1.5 Decreased killed or seriously injured casualties on Suffolk roads
	2.2 Increasing the levels of physical activity and encouraging greater use of our natural environment This will also contribute to achieving 1.1.7, 1.1.8, 1.2.2, 3.2.1 and 3.2.3	2.2.1 Reduction in prevalence of obese adults 2.2.2 Increase in the proportion of physically active adults 2.2.3 Increased utilization of green space for exercise/health reasons
	2.3 Decreasing the harm caused by alcohol to individuals and communities	2.3.1 Decreasing the rate of alcohol related hospital admissions 2.3.2 Reduced crime and antisocial behavior 2.3.3 Reduction in reoffending
	2.4 Improving access to suitable housing	2.4.1 Decreased No. of households in fuel poverty 2.4.2 Increased proportion of affordable homes available 2.4.3 Less Statutory homelessness 2.4.4 Decreased proportion of households in temporary accommodation 2.4.5 Decreasing excess winter deaths

Strategic Outcomes, Priority Areas and Key Indicators

Strategic outcome	Priority areas	Key measures (Indicators)
Outcome 3 Older people in Suffolk have a good quality of life	3.1 Ensuring that health and social care services are integrated at the point of delivery	3.1.1 Decreasing emergency admissions within 30 days of discharge from hospital 3.1.2 Proportion of people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services. 3.1.3 Proportion of people who use services and their carers who reported that they had as much social contact as they would like. 3.1.4 Increased proportion of people with long term conditions supported to manage their condition. 3.1.5 Increased proportion of people who are able to die at home.
	3.2 A focus on prevention including the promotion of healthy lifestyles and self care	3.2.1 Decreasing falls and injuries in the over 65s 3.2.2 Decreasing hip fractures in over 65s 3.2.3 Increased proportion of over 65s receiving self directed support 3.2.4 Increased proportion of vulnerable people achieving independent living 3.2.5 Increased community-based opportunities to promote personal wellbeing indicative measures 3.2.6 Decreasing permanent admissions to residential and nursing care homes
	3.3 A focus on reducing loneliness and social isolation for older people	3.3.1 Increased self reported wellbeing
Outcome 4 People in Suffolk have the opportunity to improve their mental health and wellbeing	4.1 Ensure that mental health is everyone's business not just health, social care and the voluntary sector but employers, education, and the criminal justice system	4.1.1 Increased rates of employment for those with a long-term health condition including those with a learning difficulty/disability or mental illness 4.1.2 An increase in the proportion of people with mental illness or disability in appropriate settled accommodation 4.1.3 An increase in the proportion of people assessed for substance dependency issues when entering Suffolk prisons 4.1.4 Decreasing people in prison who have a mental illness or significant mental illness 4.1.5 Increased rates of adults in contact with mental health service in employment
	4.2 Increase access to support for improving the emotional health and wellbeing of children including access to child and adolescent mental health services.	4.2.1 Improved emotional wellbeing of looked after children 4.2.2 Decreased hospital admissions caused by unintentional and deliberate injuries in under 18s
	4.3 Ensure that there is seamless mental health provision across agencies but also for those with multiple problems (drugs & alcohol misuse and mental ill health)	4.3.1 Increasing successful completion of drug treatment 4.3.2 Increased young people in drug or alcohol treatment referred from child and families service 4.3.3 Increasing adults in alcohol treatment referred from criminal justice
	4.4 Bringing together all elements of physical and mental wellbeing in recognition that physical and mental health are inter-dependent	4.4.1 The above indicators and 4.4.2 Decreased under 75 mortality in adults with serious mental illness 4.4.3 Decreased rates of suicide

Case Studies of Good Practice Within the Priority Areas

1 Outcome one: Every child in Suffolk has the best start in life

Family focus to supporting health and wellbeing

A Portuguese family living at Westvilla (a hostel in Ipswich) was referred to Sarah, a Families Information Outreach Coordinator (FIOC) as they were interested in a funded childcare place for their 2 year old daughter Marie.

When the FIOC contacted them, they had moved from the hostel and were living in central Ipswich. The family were socially isolated having only lived in England for a very short period of time.

The FIOC visited the family at home to arrange for Marie to attend a pre-school. Sarah accompanied the family to the pre-school, and as they walked along, she pointed out useful places to them such as the Post Office, primary school, local shops and chemist. Sarah also showed them where the playbus stops so they had another option of where to take their daughter to play.

They arranged for Marie to start the following week at the pre-school.

Sarah also spent time talking to Marie's parents about their local children's centre and gave them a timetable and map, and completed a referral form for the family.

Sarah discussed the family home and explained about the Community Care Grant which could help them to live independently in their community. Sarah also told them about a project providing cheap items of furniture for their home.

Marie's mother Carla spoke little English but her father was able to explain everything to her. Sarah talked to them about how English lessons could be accessed as they both seemed to recognise that it would be really useful to aid her socialisation.

Sarah said, "I recently saw Marie's father and he told me that Carla is taking English lessons. She is also volunteering at the pre-school their daughter attends, and they are both really enjoying going there. He thanked me for helping his family."

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

Addressing the wider determinants of health – Case Study Ipswich Borough Council (IBC)

Chantry Walled Garden is a new initiative developed by IBC, ActivLives (formally the Town & Bridge Project) and Suffolk New College which builds on the successful People's Community Garden project which has been running since 2007.

The project has renovated a disused area of the park, namely the Walled Garden, as a horticultural learning centre for students with complex needs. It is also a community resource to support people living in areas of deprivation access 'alternative' learning to gain skills for work in a variety of settings, including the garden and in the park. The project is also developing life skills such as healthy eating, with students growing the produce, basic cookery, IT and 'keeping house'.

Chantry Walled Garden is developing a volunteer base at the site, providing opportunities for local residents to get involved in maintaining the site, learning new skills and building new social networks. This also involves working alongside IBC parks staff, outside of the project in the wider park setting. Conservation courses in partnership with the Green Light Trust have been run with students and the project is also enhancing IBC's environmental credentials by growing wildflower plugs to increase biodiversity across Ipswich's parks.

ActivLives is also developing preventative and health initiatives in the park e.g. health walks, nordic walking, buggy walking etc to keep people active, raise awareness, improve people's health and wellbeing and maintain good health.

Although a relatively new project, the impact on individuals, the environment and education is already evident. Very vulnerable young people are gaining social and life skills, their families gain valuable respite from their caring role, local communities are beginning to get involved, learning new skills, developing social networks, reducing social isolation and building social capital. The project is raising awareness about environmental issues and involving people in how they can help improve where they live. The plant nursery, which is currently being developed, will provide opportunities for people to learn business skills, gain valuable work experience and employment.



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

Management of Health and Social Care for Older People.

Consistent with the report to the Suffolk H&WB, the Great Yarmouth and Waveney System Leadership, Health and Wellbeing Partnership (SLP) is taking responsibility for establishing and overseeing a whole-system model for the proactive management of health and social care for older people.

Partner organisations have adopted a simple set of shared commissioning objectives:

- Helping people to stay as healthy as possible in their own homes.
- Encouraging people's independence through healthy ageing and self-care.
- Reducing the costs of health and social care by avoiding unnecessary admissions to either hospitals or care homes.

Integral to the model is the development of multi-disciplinary operational networks for the delivery of a proactive approach to maintaining and re-enabling independence for older people, with shared information, assessment and care planning processes, covering 5 major themes:

- Accessing and linking with communities and assets, emphasising primary prevention.
- Self-care and carer support.
- Case management.
- An integrated crisis response service, with pathways to intermediate care and urgent care systems.
- Discharge coordination, including a "pull" approach to hospital and care homes discharges, incorporating intermediate care.

Operational Health and Social Care delivery is coordinated through the Great Yarmouth and Waveney Integration Group – reporting to the SLP through the Clinical Transformation Board.

To ensure that short term steps towards increasing integration are consistent with an agreed destination for services - the Great Yarmouth and Waveney Integration Group has established a workstream responsible for identifying the characteristics of an "ideal" integrated delivery model and for appraising options for implementation of this in the Great Yarmouth and Waveney areas.

Short term gains are being developed as building blocks for the future and include:

- Identifying the services to be aligned and co-located in multidisciplinary neighbourhood teams
- Establishing how these generic teams link to specialist services (including falls prevention) and to voluntary and community resources
- Developing a beds model across health and care
- Quantifying service capacity requirements based on a thorough analysis of demand
- Enabling operational coherence through shared information systems
- Involving customers in the changes
- Developing metrics to show performance and financial progress.

Clear components of integration which we aspire to achieve in partnership with providers of services are:

- Single point of access for information on all local health and social care services
- Single point of telephone advice and information on health and social care services using the 111 number
- Co-location of services to local communities where opportunities arise to achieve this with care closer to home where clinically possible and economically viable to do so
- Single assessment processes
- Personalised, integrated health and social care plans for people with complex health and social care needs which allow people to make informed choices about their care
- Empowerment of people to better manage, and take increasing responsibility for their own care and health
- Flexible and high quality services which work together to provide integrated care packages which reduce duplication, and improve user experience
- Better outcomes for local people based on the outcomes they wish to see for themselves as individuals. These might be more independence, a job or leisure activity, or to remain in their own home.



4 Outcome four: **People in Suffolk have the opportunity to improve their mental health and wellbeing**

The Suffolk Wellbeing Services for those with mental ill health

This email was received by the wellbeing service. The names have been changed.

Dear Sally

I write to pass on my compliments about Trish, who has been my Cognitive Behavioural Therapist since January this year. I wanted to email you because Trish has assisted me massively in my battle against depression and anxiety over the last few months. I self-referred myself to the service in November 2011, after some serious problems at work over the way I was treated, made me extremely depressed and I was feeling suicidal because things had got so bad. Trish has taught me various techniques through CBT to assist me deal with my perfectionist traits and depression. She has been extremely supportive, very flexible with appointment time and dates and has encouraged me to do things that I enjoy. I cannot thank her enough for the excellent service she has provided me with. I am pleased to report that my mental health has improved dramatically in the last couple of months and I am really enjoying life again and managing at work which was always the biggest problem for me. The combination of the CBT techniques and anti-depressants has really turned my life around for the positive.

I wanted to email you personally to express my thanks and gratitude for Trish's assistance rather than just filling in an anonymous questionnaire.

Many thanks
Helen

Dear Helen

Thank you very much for this lovely compliment and taking the time to e-mail me personally, it is a real pleasure to see this and to hear first hand from some one who has used our service the difference it has made to your life.

I am very proud of the clinicians within the service and the work that all of them do day to day to support our service users along the road to wellbeing. Trish is a credit to her profession and I will make sure she knows her efforts have been recognised.

I wish you well for your future; it sounds like you have been through an extremely difficult time in your life and are now on your way to brighter things. Your willingness to engage with Trish in finding strategies and working to put into practice the things you learnt with her have no doubt been pivotal in this and you should also be congratulating yourself for finding the resilience to want to change and move on. This is the first and often the hardest step to make and you did it, well done!

My very best wishes
Sally

Hello Sally

Thank you for your email back and your very kind comments. The other thing I meant to say was, is that Trish has re-assured me that there should be no stigma attached to experiencing a mental health problem and over time I have gradually been able to tell people that I work with what I have been going through. I have found it surprising how many other people I work with have suffered from depression in the past as well.

Suffolk Wellbeing Board: Terms of Reference

Purpose:

- To improve wellbeing outcomes for Suffolk
- To work towards establishing a Health and Wellbeing Board that is able to fulfil statutory responsibilities from April 2013 as set in the Health and Social Care Act
- To develop a stronger role in promoting joint commissioning and integrated provision between health, public health and social care
- To prepare a joint health and wellbeing strategy (in preparation for the statutory duty)
- To involve service users and local people in its work including preparing its joint health and wellbeing strategy
- To own and drive delivery of the Joint Strategic Needs Assessment
- To promote integrated approaches particularly between health, care, police and the broader public services family
- To influence commissioning plans to encourage integrated approaches that are consistent with the developing joint health and wellbeing strategy.

Membership:

The following membership is agreed for the initial 'shadow' Board and will be kept under review:

Leader of Suffolk County Council's nominee

Cabinet Member for Health and Adult Care (Suffolk County Council)

Director for Adult and Community Services (Suffolk County Council)

Cabinet Member for Education and Young People (Suffolk County Council)

Director for Children and Young People's Services (Suffolk County Council)

Director of Public Health (joint post between NHS and County Council)

Chief Executive of Suffolk County Council

Chief Executive of NHS Suffolk (to be replaced by NHS Commissioning Board from April 1st)

The Chairman and Accountable Officer for each Clinical Commissioning Group (3)

Representatives for District and Borough Councils (4)

(One for Mid Suffolk and Babergh District Councils, one for Forest Heath District Council and St Edmundsbury Borough Council, one for Waveney and Suffolk Coastal District Councils and one for Ipswich Borough Council)

Representative for HealthWatch

Suffolk's Police and Crime Commissioner and/or Chief Constable of Suffolk Constabulary

Chief Constable of Suffolk Constabulary

Representative of Suffolk's Voluntary and Community Sector Congress

Representative of Suffolk's Chief Executives Group

Members will provide a nominated substitute to ensure there is consistency of attendance

Joint Health and Wellbeing Strategy for Suffolk

Glossary of terms

Adult Social Care Outcomes Framework

The Adult Social Care Outcomes Framework is used both locally and nationally to set priorities for care and support, measure progress, and strengthen transparency and accountability.

Asset based approach

Describes assessing and building on the strengths and resources in a community (their assets) as opposed to what they don't have (their needs).

Buggy walking

Walking routes suitable for prams and buggies.

Cardiovascular disease

A term used to describe a variety of heart diseases, illnesses and events that impact the heart and circulatory system, including high blood pressure and coronary artery disease.

Census

Census statistics help paint a picture of the nation and how we live. They provide a detailed snapshot of the population and its characteristics and provide information that government needs to develop policies, and to plan and run public services such as health and education.

Child poverty

Children are said to be living in relative poverty if their household's income is less than 60% of the median national household income. In 2010/11 this was less than £251.40p per week before housing costs.

Children's Centre

Offers a range of services for families with children from birth to five years in Suffolk.

Chlamydia infection

A common sexually transmitted disease.

Chronic lung disease

A group of lung diseases that block airflow and make it increasingly difficult to breathe

Clinical Commissioning Group (CCG)

Groups of GPs, including other health professionals who will, from April 2013, commission the majority of NHS services for their patients.

Cognitive Behavioural Therapy (CBT)

CBT can help to change how you think ('Cognitive') and what you do ('Behaviour'). Unlike some of the other talking treatments, it focuses on the 'here and now' problems and difficulties. Instead of focusing on the causes of distress or symptoms in the past, it looks for ways to improve state of mind now.

Commissioning

The process by which the health and social care needs of local people are identified, priorities determined, appropriate services purchased and outcomes reviewed.

Community Care Grant

A Community Care Grant does not have to be paid back. Grants are intended to meet a need for community care and help people to live as independently as possible.

Coronary heart disease (CHD)

Develops when the arteries supplying blood to the heart become partially or wholly blocked. This causes symptoms of chest pain which is temporary and treatable. CHD can result in a heart attack if the blood supply to the heart is stopped for long enough to cause damage.

Dementia

Used to describe a syndrome in which there is progressive decline in multiple areas including decline in memory, reasoning, communication skills and the ability to carry out daily activities.

Deprived areas

Geographic areas that have significantly higher levels of unemployment and lower rates of income per head than the national average.

Diabetes

A life-long condition where the amount of glucose in the blood is too high as the body cannot use it properly.

Early intervention

Intervening early and as soon as possible to tackle problems emerging for children, young people and their families or with a population most at risk of developing problems. Effective intervention may occur at any point in a child or young person's life.

Educational attainment

Refers to the highest level of schooling a person has reached.

Environmental sustainability

A state in which the demands placed on the environment can be met without reducing its capacity to allow all people to live well, now and in the future.

Excess winter deaths

The number of excess winter deaths are defined as the difference between the number of deaths which occurred in the winter months of December to March and the average number of deaths which occurred in the preceding August to November and the following April to July.

Families Information Outreach Coordinator

Help to families including explaining their childcare options and offering advice and help about paying for childcare.

Frail elderly

Older persons (usually over the age of 75 years) who are afflicted with physical or mental disabilities that may interfere with the ability to independently perform activities of daily living.

Fuel poverty

A household is classified as fuel poor when it would need to spend more than 10% of its income on energy in order to maintain an adequate level of warmth.

Fully engaged scenario

The 2002 Wanless report (Securing good health for the whole population) set out three scenarios of how much it would cost to provide a world-class health service in Britain by 2022. At best was a "fully engaged" scenario in which people adopted healthier lifestyles and NHS professionals responded by increasing productivity by up to 3% a year.

Green Light Trust

An environmental charity that helps people, communities and organisations create sustainable living and protect our planet.

Green space

An area of grass, trees or other vegetation set apart for recreational or aesthetic purposes in an otherwise urban environment.

Health and Social Care Act 2012

Introduced changes to the structure of the NHS in England, intending to put clinicians at the centre of commissioning, free up providers to innovate, empower patients and give a new focus to public health.

Health and Wellbeing Board

Set up in every upper-tier local authority to improve health and care services and the health and wellbeing of local people. The Board brings together key commissioners to assess the needs of the local population through the Joint Strategic Needs Assessment, to produce a Health and Wellbeing Strategy to inform the commissioning of health, social care and public health services and to promote greater integration across health and social care.

Health inequalities

The differences in health, life chances and life expectancy between different geographical areas and different groups of people.

Healthy life expectancy

Defined as the number of years that a person is expected to continue to live in a healthy condition.

Heart failure

Term used when the heart becomes less efficient at pumping blood around the body, either while you are resting or active.

Index of Multiple Deprivation (IMD)

Deprivation relates to poverty, disadvantage and ill health. Currently deprivation at a local level is measured by the IMD with seven areas covering income, employment, health and disability, education, skills and training, barriers to housing and services, crime and living environment.

Inequalities

Inequality is different from poverty but related to it. Inequality concerns variations in living standards across a whole population.

Integrated services

Bringing together the management and delivery of different services so that users receive continuous care

from diagnosis, to treatment, care and prevention, according to their needs over time and across different levels of the system. Integration is a means to improve services in relation to access, quality, user satisfaction and efficiency.

Intermediate care

A range of services designed to facilitate the transition from hospital to home, and from medical dependence to functional and social independence.

Joint Health and Wellbeing Strategy

A high level, overarching framework to address the needs identified in the Joint Strategic Needs Assessment and set out agreed priorities for action.

Joint Strategic Needs Assessment

An objective analysis to identify the health and wellbeing needs of the local population. By bringing together a wide range of qualitative and quantitative data, including the views of service users, it creates a shared evidence base for planning and commissioning services.

Life expectancy

The average number of years that a person can be expected to live if current mortality trends continue to apply.

Lifecourse approach

The lifecourse is a culturally defined sequence of age categories that people are normally expected to pass through as they progress from birth to death.

Local Enterprise Partnership

A voluntary partnership between local authorities and businesses to help determine local economic priorities and lead economic growth and job creation.

Long term conditions

The Department of Health has defined a long term condition as being a condition that cannot, at present be cured; but can be controlled by medication and other therapies.

Looked after children

Children and young people looked after by the state in accordance with relevant rules and regulations.

Marginalised young people

Alongside the growing gap between affluent and less affluent communities, the gap between disadvantaged young people and their more affluent peers is also growing. Many of these young people face multiple challenges – they are disengaged from the labour market and education and many of them suffer from health problems. Marginalised young people are also likely to come from families that have been in debt and they may struggle with debt themselves.

Most Active County

A Suffolk wide collaboration to use the momentum of the London 2012 Olympic and Paralympic Games to promote healthy, active lifestyles, shift inactive behaviours and address the barriers that communities or individuals face in accessing sport, leisure and physical activity opportunities.

Neighbourhood Partnership Networks

Partnership approach working to make local services better for communities.

NHS health checks

An NHS Health Check aims to help lower the risk of four common but often preventable diseases: heart disease, stroke, diabetes and kidney disease. It is for adults in England aged between 40 and 74 who haven't already been diagnosed with any of those four diseases.

NHS Outcomes Framework

This framework contains indicators to help the health and care system to focus on measuring outcomes and provide an overview of how the NHS is performing at a national level.

Nordic walking

Nordic walking is fitness walking with specially designed poles. Compared to regular walking, Nordic walking (also called pole walking) involves applying force to the poles with each stride.

Not in education, employment or training (NEET)

Young people aged 16 to 18 who are not in education, employment or training are referred to as NEETs.

People's Community Garden

The People's Community Garden, based at Maidenhall Allotments in Ipswich, provides an outdoor learning space for people of all age groups, backgrounds, disabilities and cultures to grow fresh produce, plants and herbs and learn about the environment and wildlife in the area.

Postnatal depression

Postnatal Depression is a depressive illness which affects between 10 and 15 in every 100 women having a baby. The symptoms are similar to those in depression at other times. These include low mood and other symptoms lasting at least two weeks.

Premature/early death

Defined as deaths occurring before age 75 years.

Prevalence

The proportion of a population with a disease at a given moment in time.

Public Health Outcomes Framework

Sets out the desired outcomes for public health and how these will be measured to show progress each year. They reflect a focus not only on how long people will live but on how well they live at all stages of life.

Reablement services

Reablement is about giving people over the age of 18 years the opportunity, motivation and confidence to relearn/regain some of the skills they may have lost as a consequence of poor health, disability/impairment or accident and to gain new skills that will help them to develop and maintain their independence.

Relative poverty

Children are said to be living in relative poverty if their household's income is less than 60% of the median national household income.

Safer Suffolk Partnership Board

The strategic partnership responsible for working together to deliver community safety outcomes and any relevant local targets.

Self harm

When somebody intentionally damages or injures their body. It is often a way of dealing with deep emotional

feelings like low self-esteem or a way of coping with traumatic events.

Social capital

The extent to which people are embedded within their family relationships, social networks and communities, and have a sense of belonging and civic identity.

Social inclusion

A socially inclusive society is defined as one where all people feel valued, their differences are respected, and their basic needs are met so they can live in dignity.

Social isolation

The absence of social interactions, contacts, and relationships with family and friends, with neighbours on an individual level, and with "society at large" on a broader level.

Social networks

A social structure consisting of individuals or groups who are connected to each other, for example through friendships.

Socio-economic factors

The social and economic experiences that shape one's personality, attitudes and lifestyle. These include education, income, occupation, area in which you live, religion, ethnicity and culture.

Statutory homelessness

The official incidence of homelessness, including those households who are eligible, unintentionally homeless and in priority need for which the local authority accepts responsibility for securing accommodation under Housing Act legislation.

Suffolk family focus initiative

Part of the Government's Troubled Families initiative, this is a three year project focused on supporting families most in need of long term, intensive support. Working to make real changes and improve the quality of life for 1150 families in Suffolk, the project will be helping them overcome issues such as truancy, crime, anti-social behaviour and unemployment.

System Leadership Board

A partnership Board to identify and agree on areas of beneficial joint working, agree plans to deliver joint strategic aims where cross organisational co-operation is required and to scrutinise progress of the joint delivery workstreams and remove blockages to progress.

Town and Bridge Project (ActivLives)

ActivLives, previously known as the Town and Bridge Project, is now officially an independent charity, working with people across Ipswich and Suffolk to support them to improve and maintain good health, both physically and mentally.

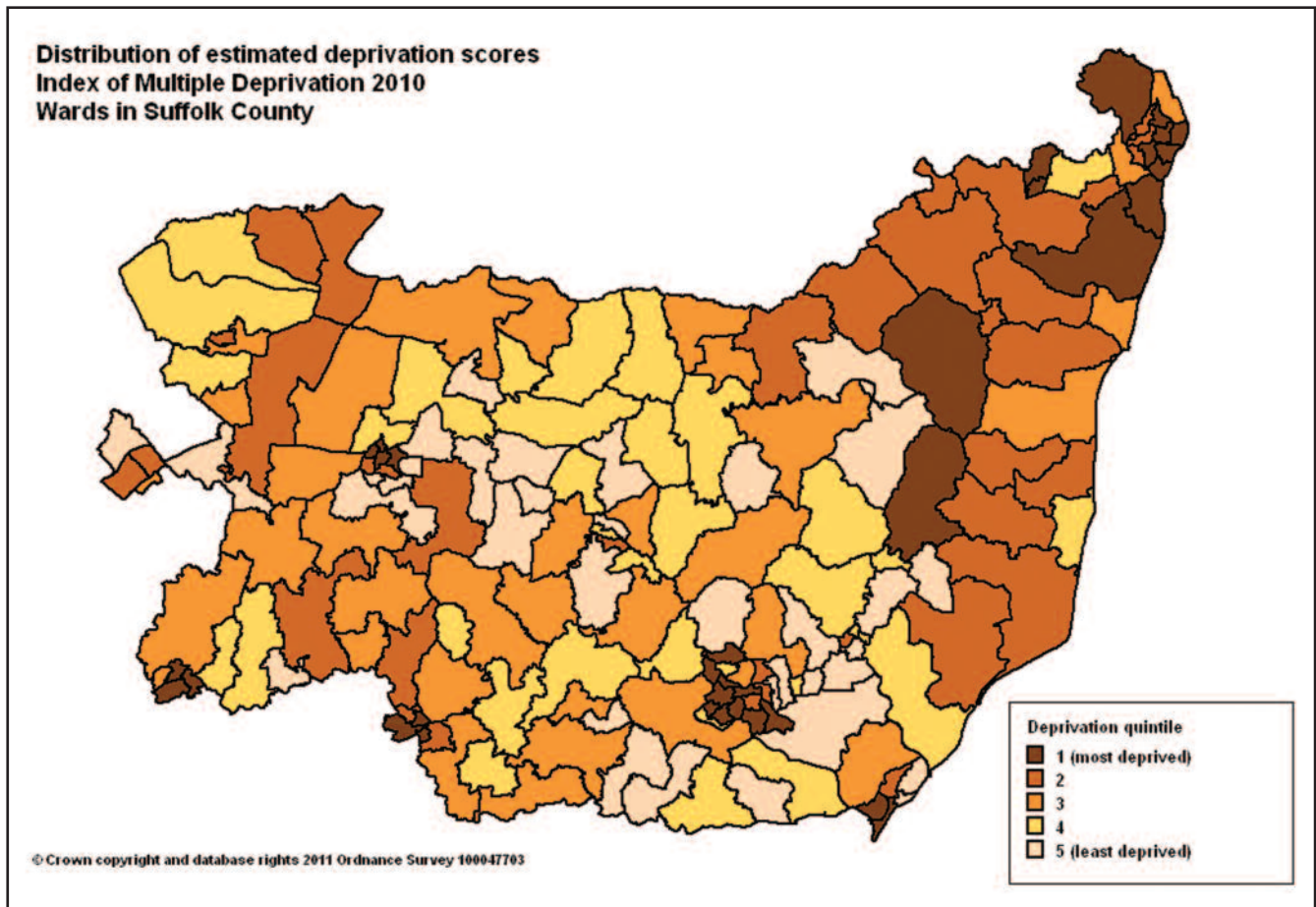
Troubled families

Families with multiple social, economic and health problems who experience the very worse outcomes and make significant demands on a wide range of local services.

Very sheltered housing

Also known as extra care housing, assisted living or simply housing with care, it is housing with various levels of care and support available on site.

Distribution of estimated Index of Multiple Deprivation



The map shows the distribution of estimated Index of Multiple Deprivation 2010 scores for wards in Suffolk. Suffolk is a relatively affluent county with pockets of deprivation which are concentrated in Ipswich and Lowestoft but also some of the smaller towns in the county, including Bury St. Edmunds, Felixstowe, Haverhill and Sudbury. Some rural wards in east Suffolk also appear deprived due to the effect poor access to services has on Multiple Deprivation scores.

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Se precisar de ajuda para ler estas informações em outra língua, por favor telefone para o número abaixo.	Portuguese
Jeżeli potrzebujesz pomocy w zrozumieniu tych informacji w swoim języku zadzwoń na podany poniżej numer.	Polish
এই লেখাটি যদি অন্য ভাষাতে বুঝতে চান তাহলে নিচের নম্বরে ফোন করুন	Bengali
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如果你需要其他語言來幫助你了解這些資訊，請撥以下電話。	Chinese
اگر شما نیاز دارید که این اطلاعات را به زبان دیگری دریافت کنید لطفاً به شماره زیر تلفن کنید.	Farsi

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