Introduction

This briefing is intended to provide an overview of health inequalities in East Sussex as part of the Joint Strategic Needs and Asset Assessment for the county. The report is divided into five main sections, looking at:

This is not intended to provide an in-depth data briefing, rather, it is intended to set out an East Sussex approach to health inequalities and to provide access to information and data sources for more detailed analysis.

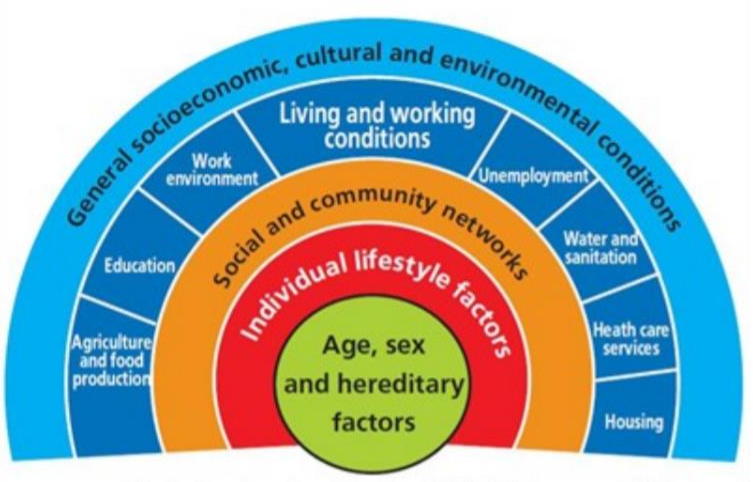
What are Health Inequalities and why do we need to tackle them

What are health inequalities?

Health inequalities are avoidable and unfair differences in health status between groups of people or communities.[1]

Health inequalities refer both to preventable differences in health status and can also refer to factors that contribute to health status, such as differences in the care that people receive or the opportunities to lead healthy lives.[2] A person's chance of enjoying good health and a longer life is influenced by the range of interacting social, economic and environmental conditions in which people are born, grow, live, work, and age. These conditions are the *determinants of health*, and include individual lifestyle factors, community influences, living and working conditions, and more general social circumstances that influence our health (figure 1).

Figure 1: The broad social and economic circumstances that together determine the quality of the health of the population

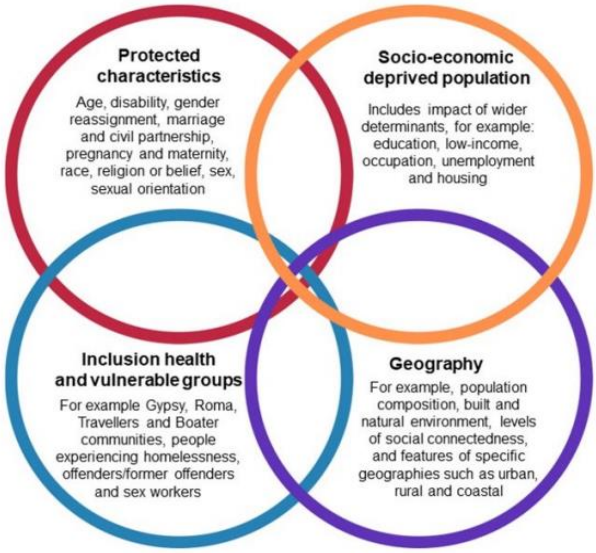


Source: Dahlgren G, Whitehead, 1991.

The 1980 Black Report showed in great detail the extent to which ill-health and death are unequally distributed among the population of Britain. It concluded that these inequalities were not mainly attributable to failings in health provision as they had been widening since the inception of the NHS. Instead they are attributable to other social inequalities influencing health. Furthermore, people's behaviour and opportunities for good health are constrained by structural and environmental factors over which they have no control. Inequalities in both health outcome and service experience arise largely because of preventable differences in the determinants of health. This means that the poorer a person's circumstances, the more likely they are to have poor health and wellbeing; a shorter life with more time spent in ill health; lower vaccination, screening and health check uptake; poorer management of long term health conditions; and later diagnosis of health conditions.[3]

Public Health England guidance outlines that health inequalities in England are often described by people's experience of four key factors: socio-economic factors, geography, specific characteristics including those protected by law, and socially excluded groups (figure 2). These domains interact with each other to benefit or disadvantage different people or groups. Who we are and our position in society is an important factor in understanding health inequalities. Some population groups with shared characteristics, such as identity or experience have increased exposures and vulnerabilities to socio-economic and environmental risks at different stages of the life course. Particular groups of people, Inclusion Health groups for example, may experience multiple overlapping risk factors for poor health, stigma and discrimination, and barriers in access to healthcare that can lead to extremely poor health outcomes.

Figure 2: domains of health inequality



Source: PHE 2021, adapted from Place Based Approaches to Reduce Inequality, 2019

Inequalities in these factors are inter-related, with disadvantages often mutually reinforcing and concentrated in particular populations. For example, in contrast to those in higher socio-economic groups, people in lower socio-economic groups tend to have a higher prevalence of risky health behaviours, worse access to care and less opportunity to lead healthy lives.[4]

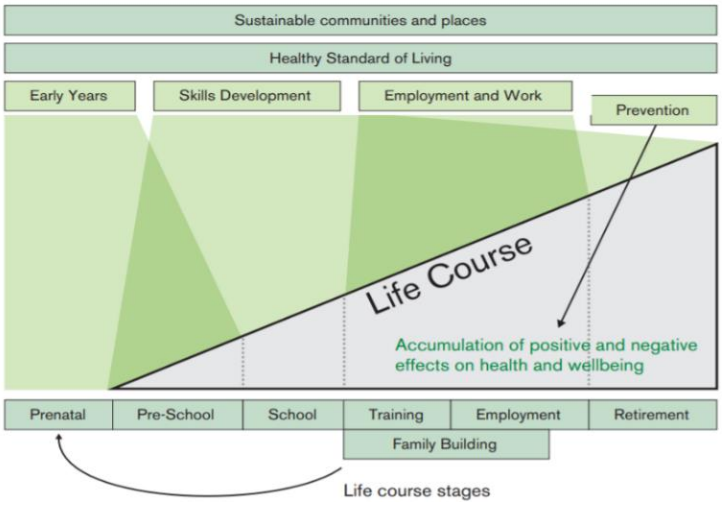
The 2010 Marmot review described these inequalities as occurring across a social gradient, and as accumulating throughout a person's life depending on their circumstances (figure 3):

- **A social gradient of health** - a systematic relationship between deprivation and life expectancy, meaning that the lower a person's social position, the worse their health. The social gradient on health inequalities is reflected in the social gradient on other areas, for example, educational attainment, employment, income, quality of neighbourhood.
- **Inequality across the life-course.** Disadvantage starts before birth and accumulates throughout life (figure 3). Social and biological influences on development start at conception, or earlier, in terms of genetic effects accumulating through pregnancy.[5] From the time of birth, the individual is exposed to social, economic, psychological and environmental experiences, which change as a person progresses through life.

The accumulation of these influences can either have a protective influence on health and wellbeing (increasing esteem, life skills, resilience and resistance to ill health and encouraging 'healthy behaviours') or can contribute to poor health (decreasing self-regard, undermining social and learning skills and creating the conditions for mental and physical ill health). However, health inequalities are not inevitable and can be significantly reduced.

The 2010 Marmot report not only outlines the strong social justice case for addressing health inequalities, but also the economic case, with an estimated annual cost of health inequalities of between £36 billion to £40 billion through lost taxes, welfare payments and costs to the NHS.

Figure 3: Actions to address health inequalities across the life-course



Source: Marmot, 2010

What are the main drivers of health inequalities?

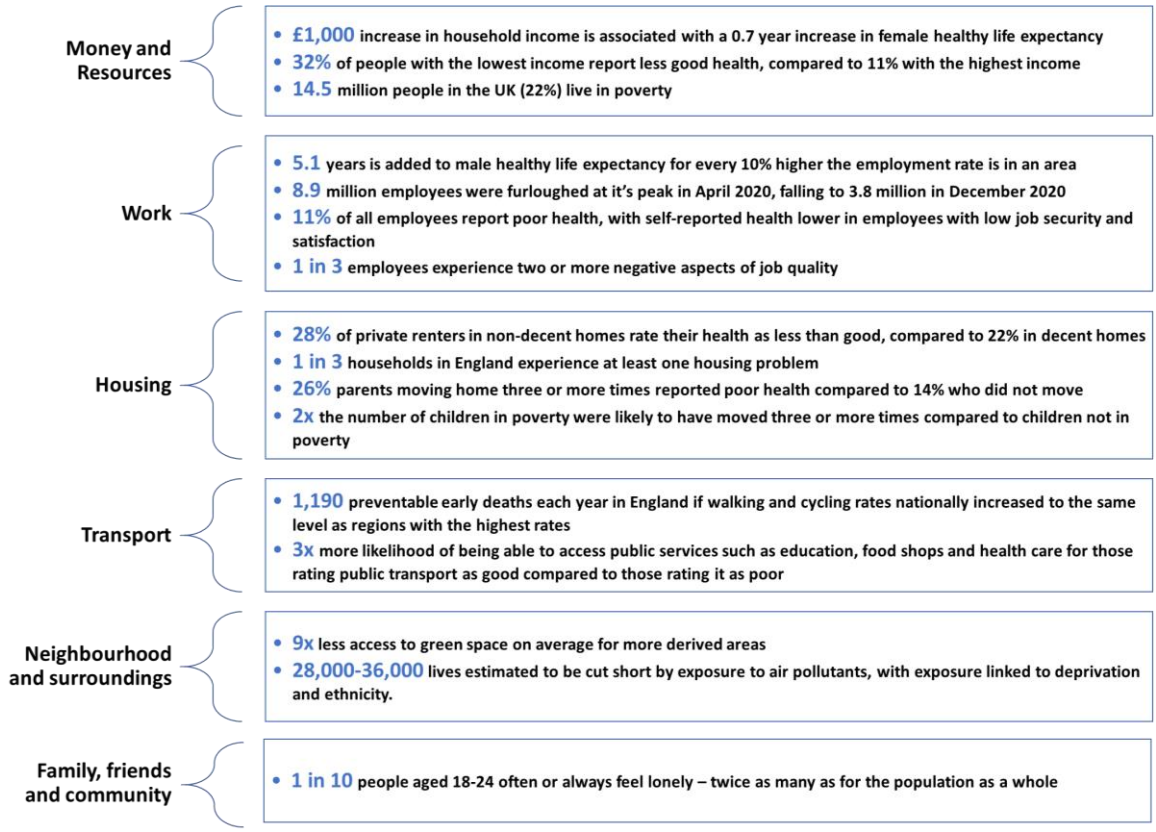
"Social inequalities in health arise because of inequalities in the conditions of daily life and the fundamental drivers that give rise to them: inequities in power, money and resources."[6]

Whilst people's behaviours, such as smoking, poor diet, physical inactivity and high alcohol consumption, are the main major causes of preventable ill health, these behavioural risks are influenced by a complex interaction between many socio-economic, cultural and environmental factors. The conditions in which we are born, grow, live, work and age significantly influence opportunities for good health, and the disparities in the accumulation of positive and negative effects of these conditions on our health and wellbeing throughout our lives is largely responsible for inequalities in health.

The Health Foundation have explored the main drivers of health inequalities in depth:

- **Money and resources** - There is a well-established link between money and resources and variations in health. Poverty – having inadequate resources to meet basic human needs – is particularly associated with worse health. This is especially the case for persistent poverty.
- **Work** - Unemployment, work quality, job security, can all have considerable influence on health. The nature of people's work matters for health, but also impacts other factors that influence health, such as having sufficient income and forming social connections.
- **Housing** - Housing affordability, quality and security can have a significant impact on people's lives, influencing their wellbeing and health.
- **Transport** - Transport can affect health directly, in terms of air pollution or active travel. It can also affect health indirectly through its relationship with other wider determinants of health, such as providing access to public services and an individual's place of work.
- **Neighbourhood and surroundings** – Neighbourhood and environment can have a marked impact on health and wellbeing. For example, access to good-quality green space is linked to improvements in physical and mental health, and lower levels of obesity. Access is likely to be worse for people in deprived areas, and areas with higher proportions of minority ethnic groups. Air pollution also impacts on health, cutting short an estimated 28,000-36,000 lives a year in the UK, with exposure linked to both poverty and deprivation.
- **Family, friends and communities** – Family and friends build the foundation for good health through positive relationships and networks for support and skill development, community cohesion and connection, opportunities for social participation, and shared ownership or empowerment which provides a sense of control and collective voice.

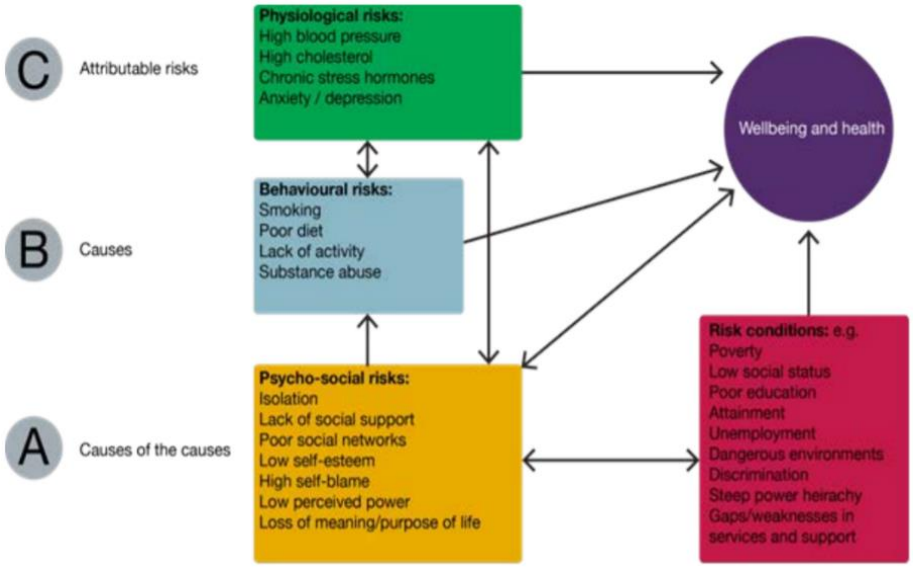
Figure 4: Key statistics on the main drivers of health inequalities



Source: Adapted from Health Foundation, 2010

The complex relationships between attributable risk factors (the conditions that people may present with which directly lead to long term illness), the main causes of these (behavioural risks), and the wider determinants, or the 'causes of the causes' is simplified in the diagram below (figure 5). Level A in the diagram or the 'causes of the causes' (yellow and red boxes) are the determinants of health. These determinants of health influence behavioural risks at level B. Attributable risks (level C) are the conditions that people may present with which directly lead to long term illness.[Error! Bookmark not defined.]

Figure 5: Patterns of risk affecting health and wellbeing: The Labonte Model of Health



Source: Public Health England, 2017

The 'causes of the causes' include key influencing factors such as housing and employment. These diverse range of factors are themselves influenced by the local, national and international distribution of power, money and resources in society which shape the conditions of daily life, causing some groups to experience different exposures and vulnerabilities to health risk. Health is therefore significantly impacted by circumstance beyond an individual's control, with health inequalities not caused by one single issue, but by a complex mix of factors.

Interventions at Level A are fundamental, with a joined-up, place-based approach recommended by Public Health England to tackle the complex causal pathway of health inequalities. These influence behavioural risks where 'primary' prevention interventions can more directly help reduce the risk of disease. Interventions aimed at attributable risk help prevent the burden of disease and early death. A joined-up approach that treats the 'place', and not just individual problems or issues, is therefore necessary to measurably reduce inequalities in health and wellbeing.

How have health inequalities changed?

The concept of health inequalities is not new and tackling these disparities has been a long-standing focus of health policy. Yet the gap between policy aims and population outcome has grown in recent years: on most measures health inequalities have got worse. Three key indicators of health inequality are life expectancy, healthy life expectancy (how much time people spend in good health/disability free over the course of their lives), and premature mortality (deaths in people under the age of 75 years). The UK has seen improvements in life expectancy every decade in the last century, up until the decade prior to the pandemic when life expectancy improvements stalled, and health inequalities were growing. The COVID-19 pandemic will have significantly contributed to this decline. The most common measure of inequality used to look at these indicators is deprivation due to the systematic relationship in the UK between geographical deprivation and life expectancy (the social gradient of health), along with age, gender and geography. While multiple other factors influence our health and wellbeing, it's important to be aware that the health data available for many are limited, and therefore gives only a partial picture of inequality. For example, the local data in this briefing doesn't capture the importance of giving every child the best start in life.

In 2020, Michael Marmot and the Institute of Health Equity published a review looking at progress against the 2010 objectives to tackle health inequalities. The report highlights the damage caused by rising child poverty, children's centre closures, reductions in per-pupil education, increasing poorly paid work, a lack of affordable housing, multi-generational and

overcrowded housing, reductions in adult social care, and the impact of climate change on the global burden of disease. Key findings:

- people can expect to spend more of their lives in poor health
- improvements to life expectancy have stalled, and declined for the poorest 10% of women
- the health gap has grown between wealthy and deprived areas, and place matters. For example, living in a deprived area of the North East is worse for your health (nearly 5 years lower life expectancy) than living in a similarly deprived area in London.

How has the COVID pandemic impacted on health inequalities?

As a result of the pandemic, we are all more aware of what is meant by health inequalities and the ways in which they impact on people's lives. The health and economic crisis of the pandemic has affected some more than others, with both immediate and longer term consequences for health and wellbeing. The Local Government Association has been undertaking a COVID-19 impact inquiry to explore the implications for health and health inequalities in the UK.

The Unequal pandemic, fairer recovery report warns that COVID-19 has created a 'perfect storm' of existing inequality and disease, leading to higher rates of coronavirus infections and death amongst the most disadvantaged people:

- poor health and existing inequalities leaving parts of the UK more vulnerable to the virus.
- stark differences in the health of the working age population – those in the poorest 10% of areas almost four times more likely to die from COVID-19 than those in wealthiest.
- the differing impact of government restrictions: from unmet health needs and mental health problems to education gaps, lost employment and financial insecurity.
- the unequal affect of the pandemic on some groups, including young people, disabled people, ethnic minority communities, care home residents, prisoners, homeless people and people experiencing sexual exploitation.
- the type and quality of work, housing conditions, and access to financial support to self-isolate contributed to increased exposure to the virus among working age adults.
- the legacy of the financial crisis – poor health (increased financial insecurity and strained public services) has left the UK more vulnerable to COVID-19's health and economic impacts.

The Local Government Association's Health Inequalities Hub explores the impact of the pandemic on health inequalities in detail across key themes including, learning disabilities, mental health, ethnicity, age and gender. In addition, the 2020/21 Joseph Rowntree Foundation (JRF) Annual report evaluates the nature and scale of poverty across the UK. It highlights early indications of how poverty has changed in our society since the start of the coronavirus pandemic, including the impact of the pandemic on work, the social security system and housing. The report also highlighted that 14.5 million people in the UK were in poverty before the pandemic, with both child poverty and in-work poverty rising for several years. Many of those already experiencing poverty were also found to have borne the brunt of the economic and health impacts of COVID-19. This included, part-time workers, low-paid workers and sectors where there are much higher rates of in-work poverty (such as accommodation and food services), Black, Asian and minority ethnic households, lone parents, private renters, social renters (who tend to have lower incomes), areas of the UK where there were already higher levels of unemployment, poverty and deprivation.

This report supports findings from Build Back Fairer: The COVID-19 Marmot Review which also highlighted that inequalities in social and economic conditions before the pandemic contributed to the high and unequal COVID-19 death toll.

In December 2021, the Race Disparity Office published the final report on progress to address COVID-19 health inequalities. The report outlines the current understanding of COVID-19 risk factors, which shows clear links to our understanding of health inequalities:

RISK FACTOR	RISK
Age	The most significant risk factor for severe illness and mortality
Sex	Risk factor for mortality, potentially due to difference in immune system response
Geography and population density	Areas with highest population density had highest death rates. This, and the local authority district someone lives in explains a large part of ethnicity disparity in COVID-19 mortality
Deprivation	Risk factor of infection and mortality. Variance in mortality rate by deprivation was greater during 'peaks' of infection. Greater risk of mortality in most deprived areas for some ethnic minorities compared to the White British ethnic group.
Comorbidities (diabetes, hypertension chronic kidney, cardiovascular or respiratory conditions)	Among those with pre-existing health conditions, there were higher mortality rates for all ethnic minority groups compared to the overall death rate for people with those conditions. Higher mortality rates among people with mental health disorders in the first wave (dementia, schizophrenia-spectrum disorders, eating disorders, pervasive developmental disorders, learning disabilities and personality disorders), but by Autumn 2021 only mortality risk for people with dementia remained raised. Increased risk of severe COVID-19 for people with sickle-cell
Lifestyle factors	Increased risk of infection and mortality linked to obesity and walking pace Higher rates of hospitalisation and mortality in current smokers than non-smokers
Occupation	Healthcare workers, indoor trade or transport and mobile machine workers had at least twice the total odds of infection compared with people employed in other professional occupations. Higher infection risk for those in the security industry, a significant proportion of who are from an ethnic minority background
Household size	A greater likelihood of contact with other adults and children in the same household among Bangladeshi and Pakistani ethnic groups meant large increases in infection rates among over-70s when schools reopened compared to people of White ethnicity. In the second wave there was an associated risk of infection, ICU admission and mortality for adults aged over 65 living with children, potentially linked to schools reopening.

	Increasing infection risk associated with increasing household size.
Air pollution	Higher mortality risk was identified in neighbourhoods with worse overall air quality than areas with better air quality
Disability	Increased risk of COVID-19 mortality among disabled people compared to non-disabled people. This may be linked to associated risks, as disabled people are often older, more likely to become infected through care home or carer contacts, experience other risk factors such as diabetes, live in more deprived areas or conditions, and experience barriers accessing care.

Source: Race Disparities Office, 2021

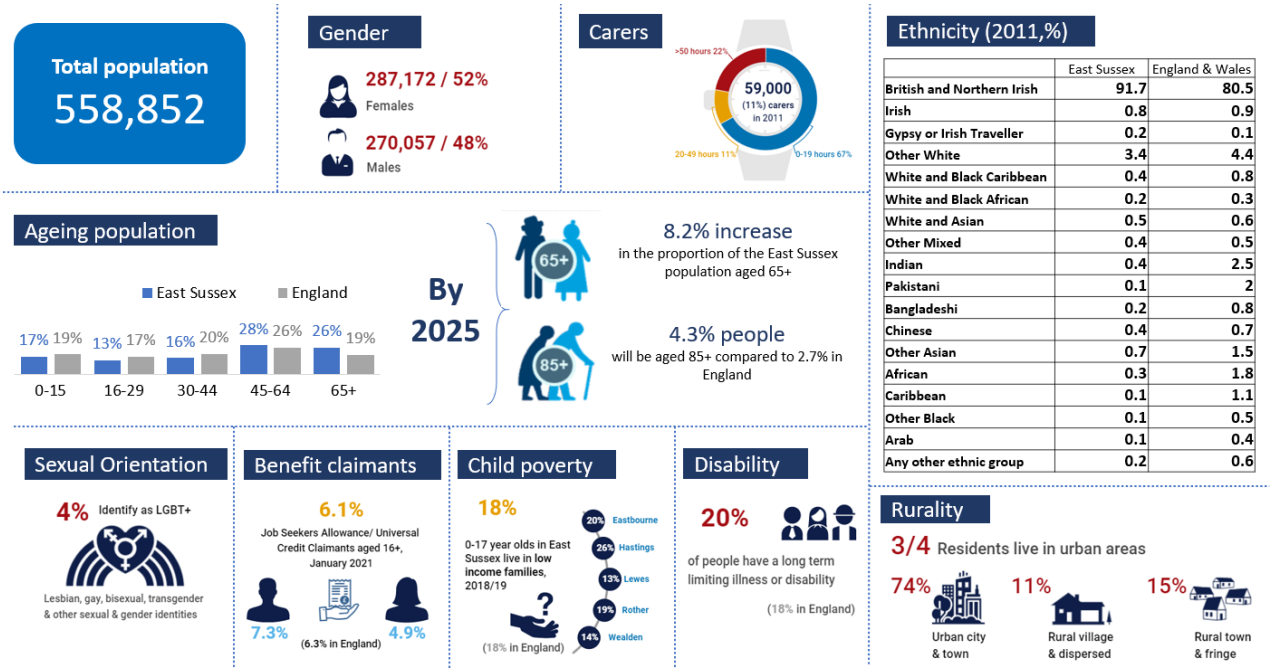
The report concludes that, as we recover from the pandemic, there is an opportunity to create a healthier, more resilient society, but onlu if action is taken to tackle structural inequalities and drive forward work programmes that reduce inequalities, prevent poor health and improve people's opportunities for better health. This requires cross-government action.

The COVID-19 Marmot Review also asserts the need for the nation's health to be the highest priority for government as we rebuild from the pandemic It emphasisises the need for long-term policies centred around equity, multi-sector action from all levels of government, and investment in public health to mitigate the impact of the pandemic on health and health inequalities.

What do health inequalities look like in East Sussex?

Local demographics

East Sussex has a much older age profile compared to England and the South East, and the ageing population is expected to increase. Compared to England, East Sussex also has a less ethnically diverse population. Three quarters of residents live in urban areas of the county, and one in five (20%) have a long-term limiting illness or disability, compared to 18% nationally (figure 6).



	East Sussex	England & Wales
British and Northern Irish	91.7	80.5
Irish	0.8	0.9
Gypsy or Irish Traveller	0.2	0.1
Other White	3.4	4.4
White and Black Caribbean	0.4	0.8
White and Black African	0.2	0.3
White and Asian	0.5	0.6
Other Mixed	0.4	0.5
Indian	0.4	2.5
Pakistani	0.1	2
Bangladeshi	0.2	0.8
Chinese	0.4	0.7
Other Asian	0.7	1.5
African	0.3	1.8
Caribbean	0.1	1.1
Other Black	0.1	0.5
Arab	0.1	0.4
Any other ethnic group	0.2	0.6

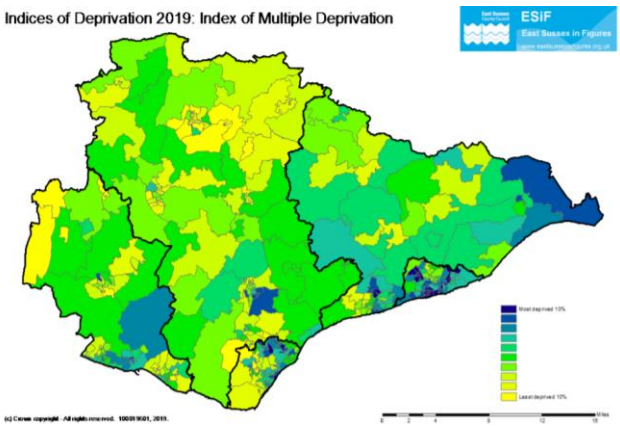
Figure 6: What does our population look like?

Source: East Sussex Public Health Intelligence

Deprivation

The Index of Multiple Deprivation (IMD) is the official measure of relative deprivation for small areas (Lower-layer Super Output Areas (LSOAs)) in England. LSOA's are areas with similar populations: an average of 1,500 residents each. The latest IMD (2019), suggests that relative multiple deprivation has risen in East Sussex since 2015. Overall, East Sussex ranks 93 out of 151 upper tier local authorities (1 = most deprived) for the proportion of LSOAs among the most deprived 10% in England. All Districts and Boroughs in East Sussex have seen a rise in relative deprivation since 2015, however, there is marked variation within the county. Deprivation is a significant driver of health inequalities and is notable along the coastal strip, particularly in Hastings which is the most deprived local authority in the South East, and 13th most deprived out of 317 lower tier local authorities nationally. In Hastings, 44% LSOAs are among the most deprived 20% nationally. Conversely, in Wealden, 32% LSOAs are in the least deprived 20% nationally (figure 7).

Figure 7: Percentage of East Sussex population living in LSOAs in each national quintile of deprivation



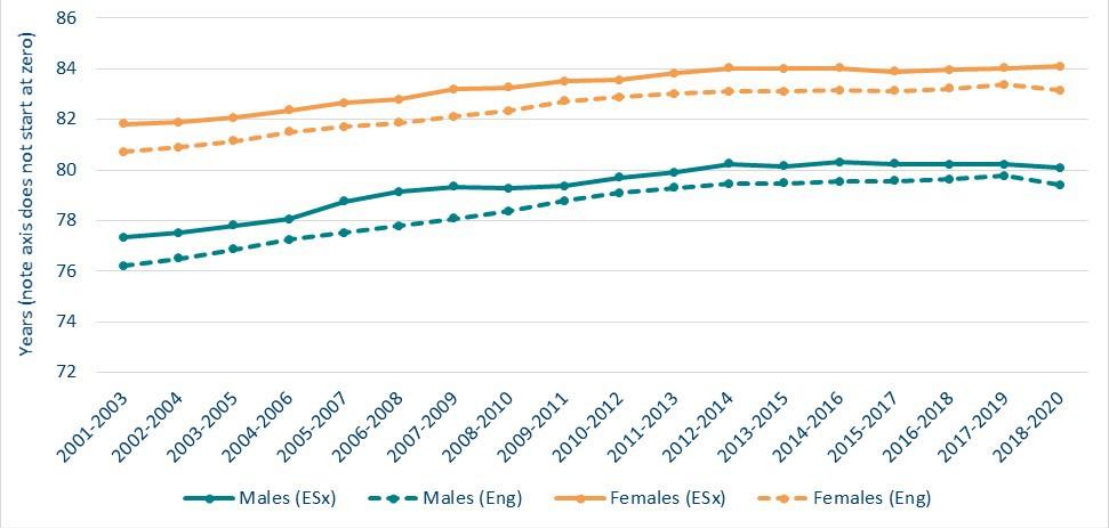
National quintile of deprivation	Eastbourne	Hastings	Lewes	Rother	Wealden	East Sussex
1 (most)	20%	44%	3%	10%	4%	14%
2	30%	30%	20%	21%	3%	19%
3	27%	14%	24%	35%	27%	26%
4	13%	12%	37%	26%	35%	26%
5 (least)	11%	0%	16%	9%	32%	16%
Total	100%	100%	100%	100%	100%	100%

Source: Index of Multiple Deprivation, 2019

Life expectancy (LE)

LE at birth is higher at an East Sussex level compared to England and higher for females than males. At an East Sussex level, in 2018-2020 LE fell very slightly in males but increased in females compared to the previous period (2017-2019). This is different to England where a more noticeable drop can be seen for the latest period. Life expectancy was increasing in East Sussex up to around 2012-2014 when it began to plateau. The latest data (2018-2020) estimates that LE for females in East Sussex is 84.1 years and for males 80.4 years (figure 8)

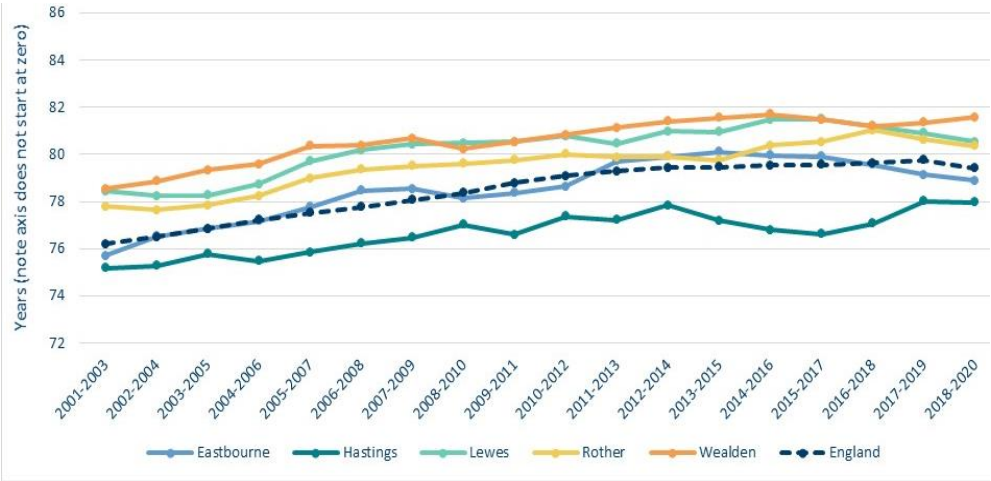
Figure 8: Life expectancy at birth 2001-03 to 2018-20, East Sussex and England



District and Borough by Sex

Life expectancy is lowest in more deprived areas of Hastings and Eastbourne, and highest in the less deprived areas of Lewes and Wealden. Compared to 2017-2019, LE fell in 2018-2020 in all areas except Wealden for males, yet for females it rose in all areas except Lewes. At a district/borough level, for males in 2018-2020, LE ranges from 78.0 years in Hastings to 81.6 years in Wealden. Generally male LE is higher than nationally with the exception of Hastings, although in recent years (and 2008-12) LE for males in Eastbourne dropped below the England rate (figure 9).

Figure 9: Male life expectancy at birth 2001-03 to 2018-20, District and Borough



For females LE ranges from 81.8 in Hastings to 85.0 in Wealden. All district and boroughs except Hastings have a higher LE than nationally (figure 10).

Figure 10: Female life expectancy at birth 2001-03 to 2018-20, District and Borough

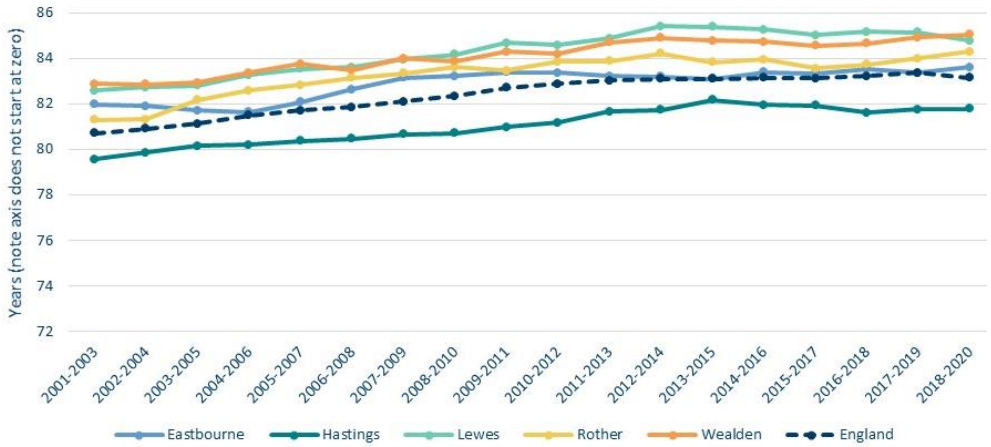


Figure 11 Shows geographical variation in life expectancy in East Sussex by Middle Layer Super Output Area (MSOA) (areas with approximate populations of 8,000). The maps are shaded to show life expectancy at birth by local quintiles (darkest patches = 20% lowest LE at birth, lightest patches = 20% highest LE). For females there is a 9.7 year gap between highest and lowest LE, and for males an 11.6 years gap. Interestingly, the MSOA with lowest male LE is in Eastbourne and not Hastings.

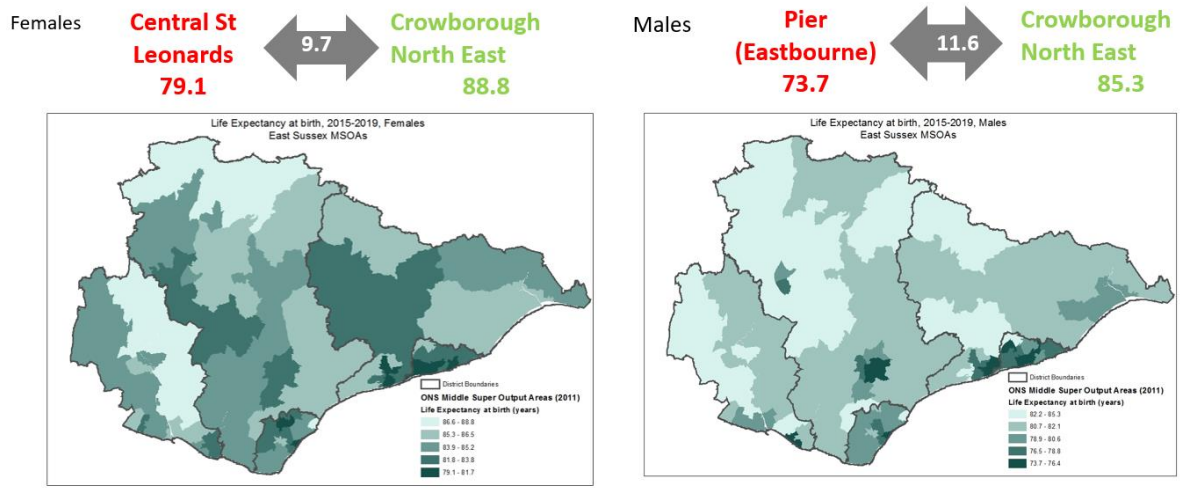


Figure 11: Geographical variation in life expectancy in East Sussex (2015-2019)

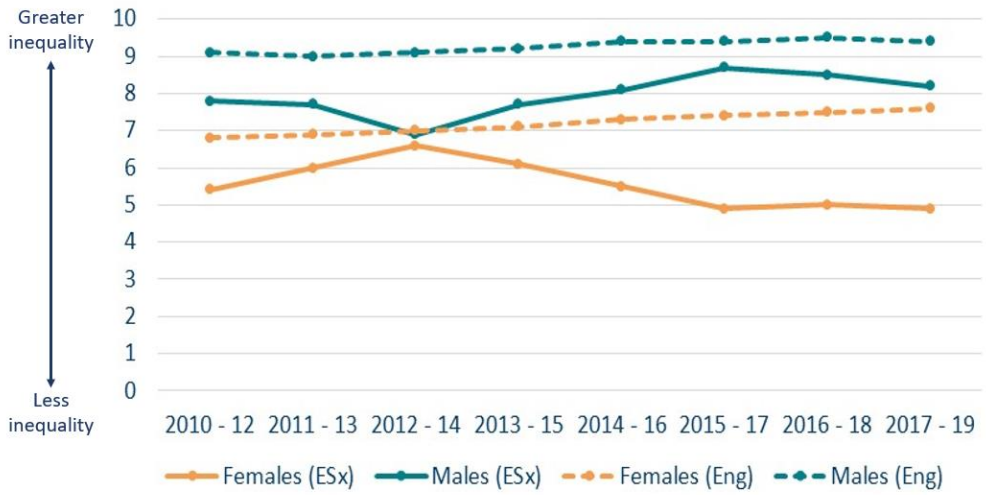
Gap in life expectancy

The Slope Index of Inequality (SII) looks at the difference in life expectancy between the most and least deprived sections of the local population. This is done by measuring the social gradient in an indicator, i.e. how much an indicator of health inequality varies with deprivation. It takes into account health inequalities by deprivation within an area and summarises this in a single number.

Nationally inequality in LE has been slowly increasing for both males and females. In East Sussex the trend is not so clear. In recent time periods it has been falling for males (but following a period of increasing inequality), and for females plateauing (but following a period of decreasing inequality).

Compared to England, East Sussex experiences lower inequality in life expectancy at birth (Figure 14). In East Sussex, the inequality is greater for males (SII = 8.2 years in 2017-2019) compared to females (SII = 4.9 years in 2017-2019) (figure 12).

Figure 12: Inequality in life expectancy (slope index of inequality) East Sussex



Within East Sussex the latest data suggest inequality is greatest in Eastbourne (SII = 9.5) for males and Rother for females (SII = 7.2). Due to variation at a smaller area, other than decreasing inequality for females in Lewes, there are no other clear trends within the county (figure 13).

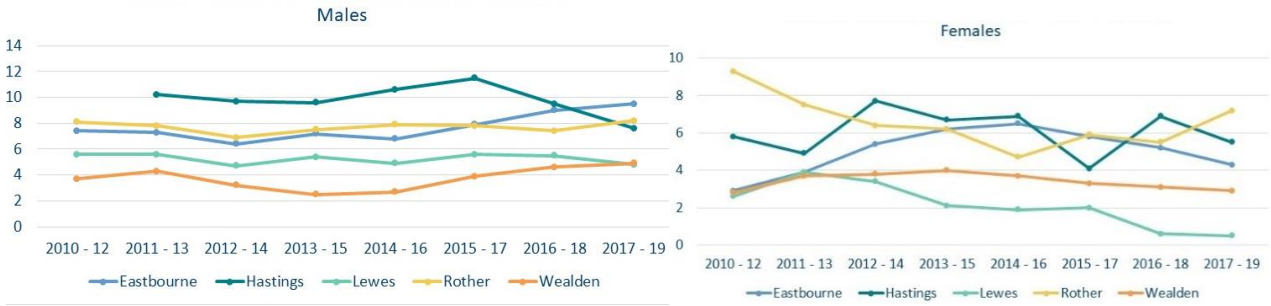


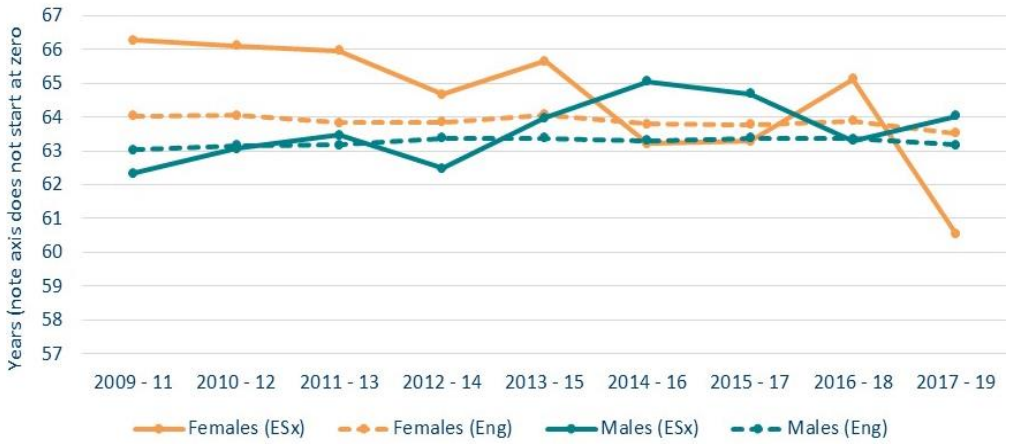
Figure 13: Inequality in Life Expectancy (Slope Index of Inequality), Districts and Boroughs: Males and Females

Healthy life expectancy (HLE)

Healthy life expectancy shows the years a person can expect to live in good health. Figures reflect the prevalence of good health and mortality among those living in an area in each time period, rather than what will be experienced throughout life among those born in the area. Marmot, and national evidence shows that people can expect to spend less of their lives in good health. We also know that the people from less affluent areas will have shorter life expectancy and often spend more of that time not in good health.

In East Sussex, average HLE is around 15 years lower than life expectancy (LE). In the latest time period (2017-2019) HLE increased for males (64.0 years), rising above the England value (63.2). However, for females in East Sussex there was a large drop from 65.1 years to 60.5, dropping below nationally (63.5) (figure 14).

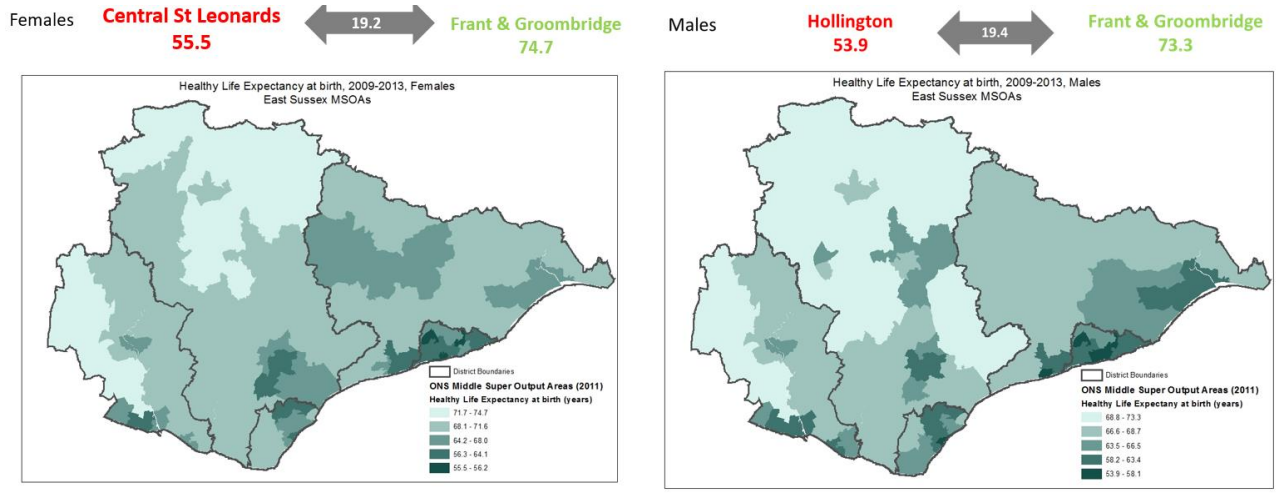
Figure 14: Healthy Life Expectancy at birth, East Sussex and England



Deprivation

Figure 16 Shows geographical variation in healthy life expectancy in East Sussex by MSOA (areas with approximate populations of 8,000). For females in East Sussex there is a 19.2 year gap between highest and lowest HLE, and for males a 19.4 year gap, over double the gap in life expectancy for both men and women (although, note the different time period of the data to figure 15).

Figure 15: Geographical variation in health life expectancy in East Sussex (2009-13)



Causes of mortality

A risk factor of ill health or mortality is an attribute, behaviour, exposure or other factor which is causally associated with increased probability of a disease or injury. These are the causes behind the causes. There are three types of risk: attributable risks (e.g. high blood pressure); psychosocial risk (e.g. isolation, poor social networks); and behavioural risks (e.g. alcohol use). There are also risk conditions affecting these risks (e.g. poverty, poor education).

In East Sussex, for all causes and all ages, cardiovascular disease (CVD) and cancer (neoplasms) are the main causes of premature mortality (deaths for people under the age of 75). Mortality due to CVD and cancer is almost four times greater than the next most common causes: neurological disorders and respiratory infections. Cancer and CVD are also the leading causes of years of life lost due to premature mortality, and years of life lost due to the sum of both premature death and years of life lived with disability (disability-adjusted life years: DALYS) (figure 16).

Figure 16: East Sussex top 10 causes of ill health and mortality, and top ten risk factors for deaths and disability-adjusted life years, 2019

Metabolic risks

Environmental/occupational risks

Behavioural risks

Deaths		DALYs (Disability-adjusted life years)		Deaths	
1) Tobacco	1098	1) Tobacco	23442	1) Cardiovascular diseases	2647
2) High systolic blood pressure	925	2) High fasting plasma glucose	16152	2) Neoplasms	2453
3) Dietry risks	781	3) High body-mass index	14725	3) Neurological disorders	665
4) High fasting plasma glucose	755	4) Dietry risks	13452	4) Respiratory infections and tuberculosis	550
5) High body-mass index	531	5) High systolic blood pressure	13294	5) Chronic respiratory diseases	544
6) High LDL cholesterol	459	6) Alcohol use	8360	6) Digestive diseases	397
7) Non-optimal temperature	353	7) High LDL cholesterol	6506	7) Diabetes and kidney diseases	140
8) Alcohol use	257	8) Occupational risks	6097	8) Unintentional injuries	139
9) Occupational risks	227	9) Non-optimal temperature	4081	9) Other non-communicable diseases	137
10) Kidney dysfunctoin	205	10) Air pollution	3195	10) Self-harm and interpersonal violence	69

Within East Sussex, the top risk factor for both deaths and premature mortality/years lived with disability is tobacco. The greatest overall risks in East Sussex are metabolic risks (high systolic blood pressure, high fasting plasma glucose, high BMI, high cholesterol and kidney disfunction), which are linked to behavioural risks (tobacco, alcohol and dietary risks), and lastly occupation/environmental risks (cold weather, occupational risks and air pollution).

Premature mortality

Premature mortality is the mortality rate for deaths of people under the age of 75.

Figure 17: East Sussex top 10 causes of premature mortality, 2019

East Sussex	
1) Ischaemic heart diseases	166
2) Cancer of trachea, bronchus and lung	136
3) Chronic lower respiratory diseases	112
4) Cancer of colon, sigmoid, rectum and anus	73
5) Accidents	72
6) Cerebrovascular diseases	68
7) Influenza and pneumonia	61
8) Cirrhosis and other diseases of liver	59
9) Suicide and injury/poisoning of undetermined intent	58
10) Cancer of breast	55

Overall in 2019 in East Sussex, the leading cause of premature mortality was ischaemic heart diseases, followed by cancers of the trachea, bronchus and lung, and chronic lower respiratory diseases (Figure 17).

Cancers of the trachea, bronchus and lung are the leading cause of premature mortality in Hastings and Eastbourne, while in Lewes, Rother and Wealden the leading cause is ischaemic heart disease. Within East Sussex, Rother is the only district or borough where accidents and suicides are not in the top ten causes of premature mortality (Figure 18).

Figure 18: Top causes of premature mortality (under 75s) by district and borough, 2019

Eastbourne		Hastings		Lewes		Rother		Wealden	
1) Cancer of trachea, bronchus and lung	29	1) Cancer of trachea, bronchus and lung	38	1) Ischaemic heart diseases	33	1) Ischaemic heart diseases	35	1) Ischaemic heart diseases	40
2) Chronic lower respiratory diseases	25	2) Ischaemic heart diseases	34	2) Cancer of trachea, bronchus and lung	25	2) Chronic lower respiratory diseases	22	2) Chronic lower respiratory diseases	25
3) Ischaemic heart diseases	24	3) Chronic lower respiratory diseases	28	3) Cancers of lymphoid, haematopoietic and related tissue	14	3) Cancer of trachea, bronchus and lung	21	3) Cancer of trachea, bronchus and lung	23
4) Accidents	21	4) Accidents	19	4) Cerebrovascular diseases	13	4) Influenza and pneumonia	16	4) Cancer of colon, sigmoid, rectum and anus	16
5) Suicide and injury/poisoning of undetermined intent	15	5) Cancer of colon, sigmoid, rectum and anus	17	5) Chronic lower respiratory diseases	12	5) Cerebrovascular diseases	14	5) Cerebrovascular diseases	15
5) Cancer of breast	15	5) Cerebrovascular diseases	17	5) Accidents	12	5) Cancer of colon, sigmoid, rectum and anus	14	5) Accidents	15
7) Cancer of colon, sigmoid, rectum and anus	14	7) Cirrhosis and other diseases of liver	16	5) Suicide and injury/poisoning of undetermined intent	12	7) Cancer of pancreas	11	7) Suicide and injury/poisoning of undetermined intent	13
8) Cirrhosis and other diseases of liver	13	8) Suicide and injury/poisoning of undetermined intent	11	5) Cancer of colon, sigmoid, rectum and anus	12	8) Cancer of liver and intrahepatic bile ducts	10	7) Influenza and pneumonia	13
9) Cancer of pancreas	12	9) Influenza and pneumonia	9	9) Influenza and pneumonia	11	8) Cancer of breast	10	7) Cirrhosis and other diseases of liver	13
10) Influenza and pneumonia	12	9) Cancer of pancreas	9	9) Cirrhosis and other diseases of liver	11	10) Dementia	9	10) Cancers of lymphoid, haematopoietic and related tissue	12
		9) Aortic aneurysm and dissection	9	9) Cancer of pancreas	11			10) Dementia	12
		9) Heart failure and complications and ill-defined heart disease	9					10) Cancer of breast	12
		9) Cancer of breast	9						

Source: PHE segment tool

Causes of inequality in premature mortality in East Sussex

To tackle inequalities in health we need to understand what is driving differences between groups by looking in more detail at the inequalities in health experienced by different parts of our population.

Sex

Figure 19 shows the relative contribution of different causes of death to the gap in life expectancy at birth for men and women.

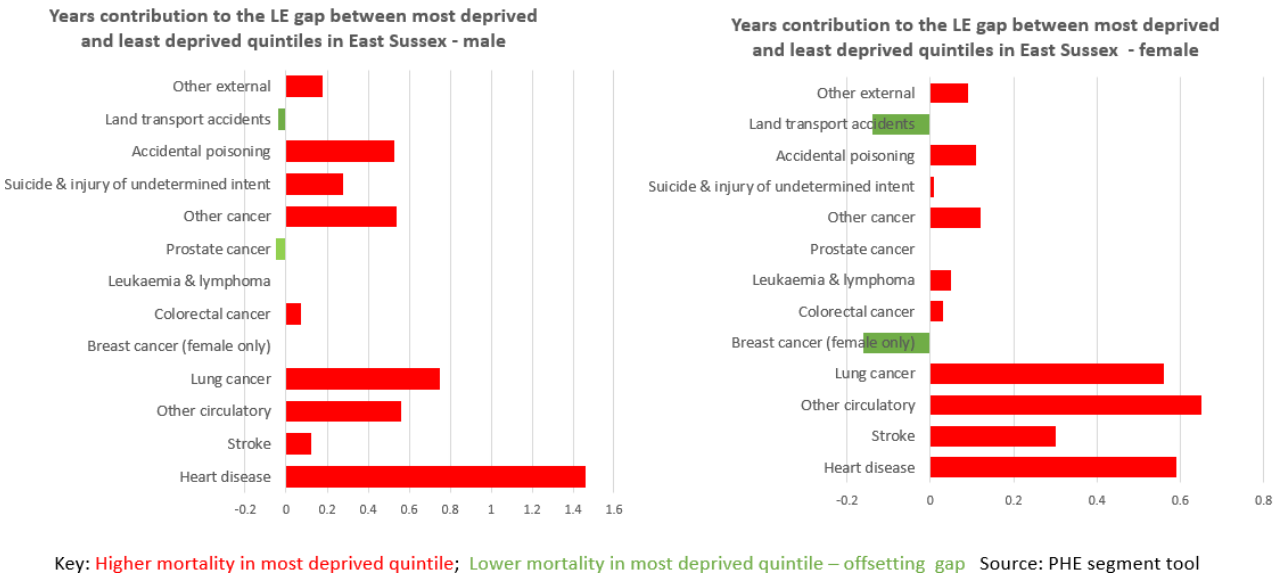


Figure 19: Number of years reduction in life expectancy at birth in East Sussex due to specific causes, by sex

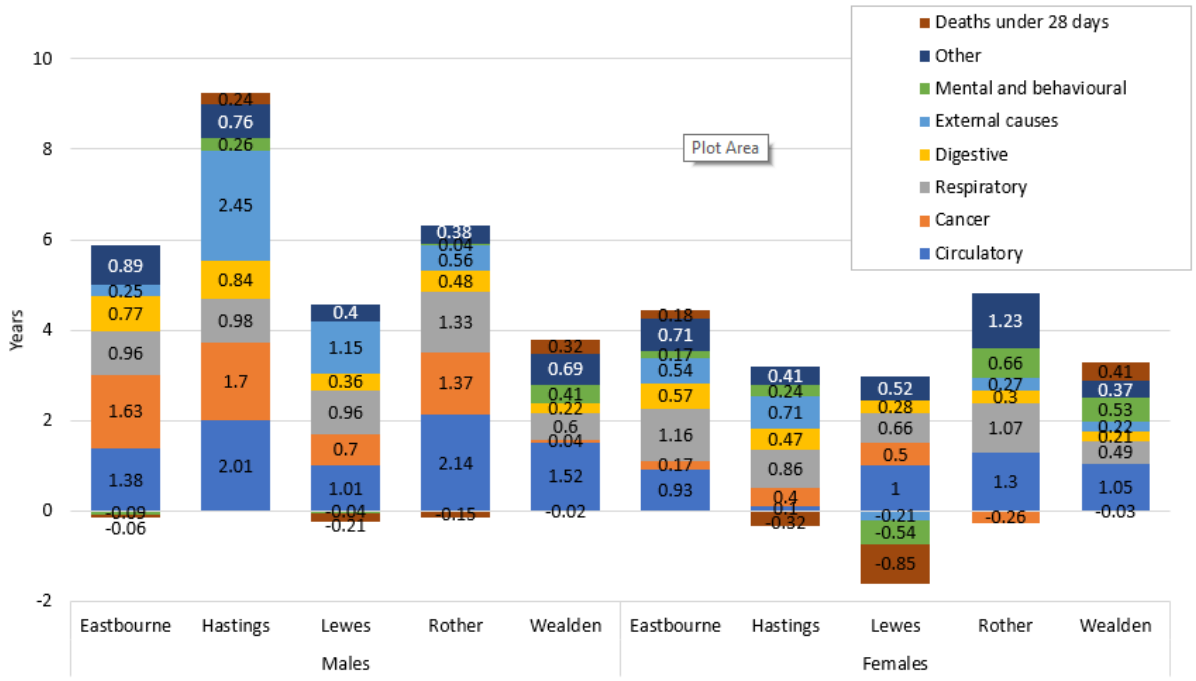
The biggest contributors to the gap between most and least deprived (the highest mortality difference) are circulatory disease (predominately heart disease, other circulatory and a smaller contribution from stroke), and cancer (primarily lung cancer). Land transport accidents, breast cancer and prostate cancer are the only causes of death which have higher mortality in the least deprived quintile.

Geography

Looking at a lower level geography reveals patterns hidden when looking at the county as a whole. This gives a better indication about where to explore further to think about interventions. Figure 20 shows that the relative impact of causes of death varies between districts and boroughs and sex. In Hastings, external causes (deaths from injury, poisoning and suicide) are a larger cause of the gap in life expectancy between most and least deprived quintiles than in other districts and boroughs, particularly for males. Eastbourne is the only district or borough where cancer is the largest contributor to the gap in life expectancy for men.

For women, respiratory conditions are the largest contributor in Hastings and Eastbourne, while for all other districts and boroughs it is circulatory disease. External causes also have a larger contribution to the gap for women in Hastings and Eastbourne than in Lewes, Rother and Wealden.

Figure 20: Broad causes of the gap in LE between most and least deprived quintiles within districts and boroughs 2015-17



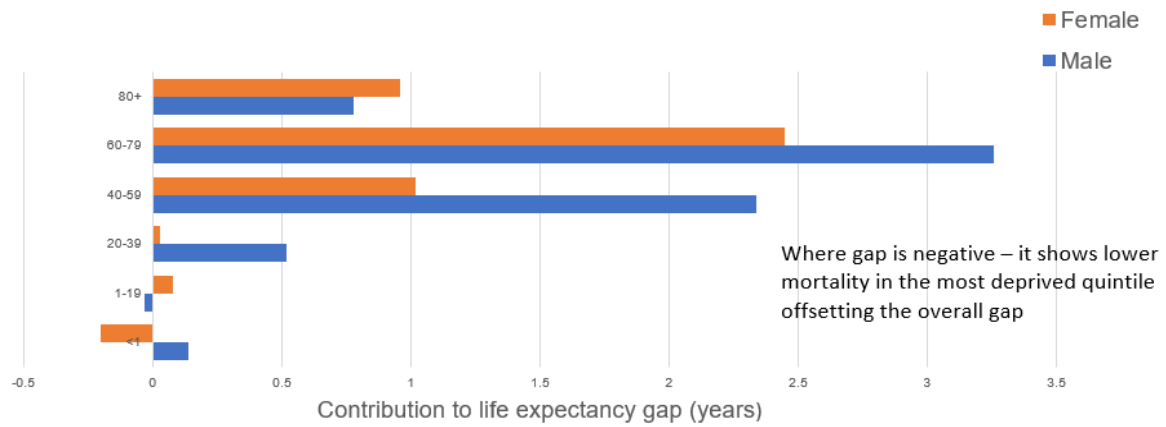
Source: PHE segment tool

These risk factors are largely modifiable in that interventions aimed at diet, smoking, alcohol, exercise, early identification and management of hypertension, cholesterol, and treatment of lung conditions could impact on the risk of disease. For example, lung cancer is a significant contributor to the gap in life expectancy, and we know that smoking is higher in lower socio-economic groups, and that there are likely to be lower rates of people going to the GP or requesting investigation of lung cancer symptoms, so intervening in these areas could reduce the gap.

Age

The greatest gap in life expectancy between the most and least deprived is amongst those aged 60-79 for both men and women. The contribution of age to the gap in life expectancy between the most and least deprived males is greater than for females between ages 20 to 80. However, for females, health inequalities and accumulation of risk has a larger impact on mortality in people aged over 80 who are most deprived compared to least deprived (figure 21).

Figure 21: Gap in LE between most and least deprived quintiles by broad age group, 2015-17



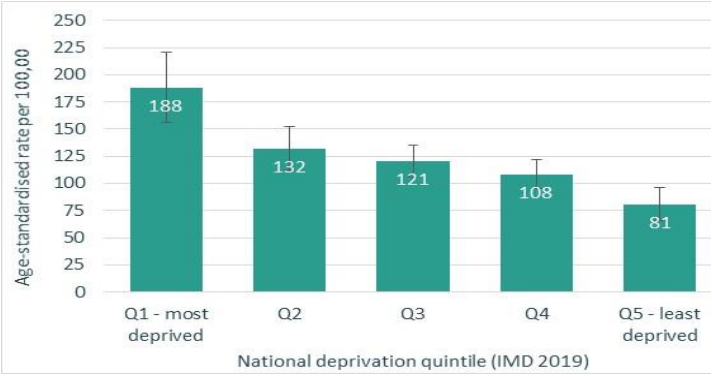
Impact of COVID-19 in East Sussex

The disproportionate impact of the COVID-19 pandemic on certain groups and populations nationally are also being seen in East Sussex. For example, there have been higher than expected COVID-19 cases in the most deprived two quintiles, constituting 32% of the East Sussex population but 35% of recorded COVID-19 cases. There have also been higher cases than expected amongst males (constituting 48% of the East Sussex population but 53% of recorded infections), and among ethnic monitorities (4% of the population and 5% of recorded infections).

There is also variation in rates of vaccination uptake and mortality from COVID-19, indicating a greater impact on more vulnerable groups. Nationally, 21% of the eilgible population aged 12 and over are unvaccinated. As at 1st January 2022, Lewes (13%), Rother (12%), and Wealden (13%) have significantly lower rates of unvaccinated individuals compared to England. However, in Hastings and Eastbourne, 20% and 18% of the eilgible population aged 12 and over are unvaccinated, with eight of the ten local areas with the highest percentage of people unvaccinated in these two areas.

Inequalities in mortality risk are also replicated in East Sussex. Local analysis of community deaths (deaths registered between January 2020 and March 2021 where COVID-19 is mentioned on the death certificate, excluding those who in care homes or a hospice who are known to be extremely vulnerable to COVID-19 risk) shows a clear association with deprivation and death from COVID-19. COVID-19 mortality for those in areas of East Sussex rated in the top 20% most deprived nationally are over twice the rate of those areas that are in the least deprived 20% nationally (figure 22).

Figure 22: Age-standardised community deaths by national deprivation quintile



Data also indicates a rise in premature mortality (all causes) across all deprivation quintiles in 2020/21 compared to 2019/20 (although not significantly), with the greatest increase in the most deprived quintile. Premature mortality also increased across all districts and boroughs in 2020/21 compared to 2019/20 (although not significantly), with the largest increase in rates in Hastings and Wealden.

A clear social gradient between COVID-19 and deprivation is also seen in emergency admissions to hospital where primary diagnosis is COVID-19, with admission rates increasing with increasing levels of deprivation. This pattern is also true of emergency admissions for all-causes not just COVID-19.

Detailed COVID-19 data is provided in the East Sussex quarterly report: More COVID facts and figures

Due to the emerging data on the impact of COVID-19 both nationally and locally, there are also potential unknown inequalities that could be vastly impacted by the pandemic that

need to be considered. For example, those who are not connected to services or support in any way such as domestic abuse victims, migrant workers who don't qualify for state-support, or those who live alone or aren't digitally connected.

Best practice

"Reducing health inequalities is a matter of fairness and social justice. In England, the many people who are currently dying prematurely each year as a result of health inequalities would otherwise have enjoyed, in total, between 1.3 and 2.5 million extra years of life[8]

Addressing health inequalities has often focused on actions by the health and care system, the NHS and the Department of Health and Social Care[7]. However, this focus misses the wider determinants of health such as education and employment, housing, social networks, the places, and environments in which we live and the extent to which it encourages exercise, a healthy diet, and important social connections. Therefore, actions to reduce health inequalities need to go beyond the provision and delivery of healthcare services, which are of course important partners in a system wide approach to improving health and wellbeing. Taking action to reduce inequalities in health does not require a separate health agenda, but action across the whole of society, and across all the social determinants of health[8]. Given health inequalities have a wide range of causes, a joined-up, multi-agency and co-produced place-based approach is necessary to tackle the complex relationship.

The 2010 Marmot review sets out a framework for action under two policy goals: to create an enabling society that maximizes individual and community potential; and to ensure social justice, health and sustainability are at the heart of all policies. The report sets out 6 areas, which covers stages of life, healthy standard of living, communities and places and ill health prevention. These formed the basis for six areas of recommendations

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

The Health Equity in England: The Marmot Review 10 Years On report, published in 2020, outlines progress against these objectives, and highlights the essential components still required to reduce health inequalities linked to socio-economic factors:

- Develop a strategy for action on the social determinants of health aiming to reduce inequalities in health.
- Ensure proportionate universal allocation of resources and implementation of policies.
- Early intervention to prevent health inequalities.
- Develop the social determinants of health workforce.
- Engage the public.
- Develop whole systems monitoring and strengthen accountability for health inequalities.

Government guidance states that to have real impact at population level, interventions to address health inequalities need to be evidenced based, outcomes orientated well resourced, sustainable and systematically delivered at a scale to reach large sections of

the population. These actions should be universal (at population level), but with a scale or intensity that is proportionate to the level of disadvantage[9]. This *proportionate universalism* would ensure that a greater intensity of action is targeted at those who most need it. Such interventions can be targeted in three ways.

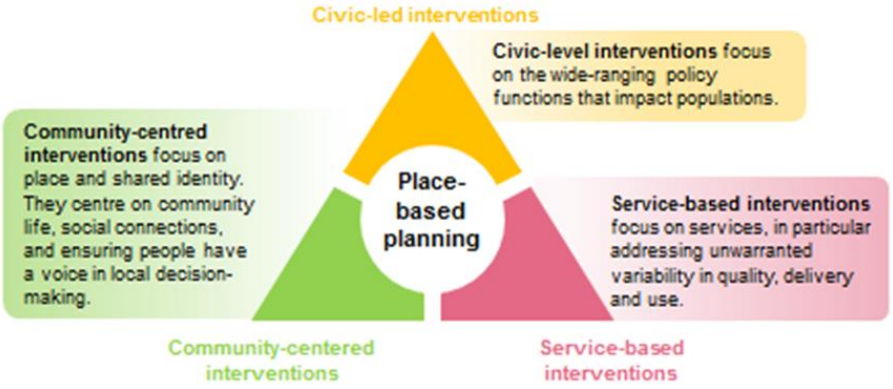
- **Intervening at different levels of risk** -. People experience different yet interconnecting levels of risk of poor health, with one risk often leading to another. For example, people may experience physiological risk (e.g. high blood pressure or high cholesterol); behavioural risk (e.g. smoking or lack of physical exercise); and psychosocial risks (e.g. loneliness and poor self-esteem). Therefore, actions and resources to address health inequalities need to understand the levels of risks and devise appropriate interventions aligned to the level of risk.
- **Intervening for impact over time** – Different types of intervention will have different impacts over different time scales. For example, improving cycle routes could increase physical activity and contribute over the longer term to a reduction in long term conditions associated with sedentary behavior and being overweight, while stopping smoking will have an immediate impact as well as longer term improvements.
- **Intervening across the life course** – Action needs to be taken to reduce the accumulation of health inequalities from before birth through to old age. In 2010, Michael Marmot emphasised how the wider determinants of health impact on people's lives and exacerbate inequalities across the life course. The review identified that in order to affect the ways determinants of health impact on people, some actions (those affecting early years, work and employment) need to be focussed on specific stages of the life course. Other actions (skills development) will impact on several stages of the life course, and some (community, standard of living) will impact at every stage of the life course.

Effective whole system strategies require system leadership and planning from a range of civic and community partners. They will need to understand and take relevant action of multi-component inventions: rooted in the place they will be delivered, that address individuals, communities, the living and working conditions and the wider socioeconomic and cultural system and policies.

PHE's publication, Place based approaches to reducing health inequalities, uses the Population Intervention Triangle (Figure 23) to describe how health inequalities can be addressed at scale through systematic collaborative leadership and action to meet local needs and priorities:

1. Individual and service-based interventions (such as workplace health and smoking cessation) use person centered approaches to address problems, and may provide information, skills, treatment or counselling.
2. Community based interventions aim to develop social cohesion, mutual support, and social interactions beneficial for health and wellbeing, by building on assets within communities such as skills, knowledge, social networks, local groups and community organisations.
3. Civic level action and interventions (healthy public policy, such as safer and healthier workplaces, better housing, and better access to health and social care) aim to improve living and working conditions, and identify health-damaging environments, both at home and at work. Civic interventions have the greatest reach of any intervention, and therefore local authorities are a critical driving force behind place-based action to reduce inequalities

Figure 23: Population Intervention Triangle (PIT) model for planning action to reduce health inequalities



Source: Public Health England, 2021

Interventions at these levels can separately impact on population health, but joint working across the interfaces between the civic, service and community sectors would have a much greater impact.

National initiatives

The NHS has launched the Core20PLUS5 approach to reducing health inequalities. This is a national NHS England and NHS Improvement approach to support the reduction of health inequalities at both national and system level. The approach defines a target population cohort – the 'Core20PLUS' – and identifies '5' focus clinical areas requiring accelerated improvement.

- The **'Core20'** is the most deprived 20% of the national population as identified by the national Index of Multiple Deprivation (IMD). The IMD has seven domains with indicators accounting for a wide range of social determinants of health.
- The **'PLUS'** is the Integrated Care System (ICS)-determined population groups experiencing poorer than average health access, experience and/or outcomes, but not captured in the 'Core20' alone. This should be based on ICS population health data. Inclusion health groups include: ethnic minority communities, coastal communities, people with multi-morbidities, protected characteristic groups, people in contact with the justice system, people experiencing homelessness, drug or alcohol dependence, vulnerable migrants, Gypsy, Roma and Traveller communities, sex workers, victims of modern slavery and other socially excluded groups.
- The **'five'** clinical areas of focus are: continuity of maternity care in the most deprived areas, annual health checks for those with Severe Mental Illness (SMI), chronic respiratory disease (with a focus on COVID-19, flu and pneumonia vaccination uptake), early cancer diagnosis, and hypertension case-finding. Governance for these five focus areas sits with national programmes; national and regional teams coordinate local systems to achieve national aims.

Many of the actions and principals of reducing health inequalities aligns with the Governments 'Levelling up' agenda. The guidance is aimed at central and local government as well as other agencies with a stake in improving health. This agenda has five guiding principles, that should work together in a long-term way across national, regional, and local systems:

- Healthy-by-default and easy to use initiatives – Initiatives that make healthy choices the default and services easy to use tend to be 'upstream interventions' targeting structural factors and not requiring much agency to improve health (individuals benefit without investing much of their own resources or effort).
- Long-term, multi-sector, multi-component action – Health inequalities are driven by an unequal distribution of the wider determinants of health. Any programme of levelling up health needs actions across multiple sectors and which are cross-government to address this unequal distribution.
- Locally designed focus – Services and programmes need to be designed around the specific needs of places and communities, especially in disadvantaged or ethnically diverse areas.
- Targeting disadvantaged communities – Disadvantaged areas and communities need bespoke interventions above and beyond what is provided to the rest of the population
- Matching of resources to need – More resources should be given to those with more need to enable the extra support they need to enjoy good health. Weighting by IMD.

Each principle is supported by case studies, such as Healthy New Towns, the Big Local initiative, and New Deal for Communities. From the evidence review and case studies, policy recommendations are

- Health should be a core part of the levelling up programme.
- A long-term, cross-government Health Inequalities Strategy is needed.
- A clear vision for levelling up health and what success would look like is needed.
- Levelling up of national and local policies should be informed and checked against the evidence-based principles outlined
- Local areas supporting the levelling up agenda need the adequate powers and resources to effect change, working closely with local communities.
- A strategic prioritisation framework is needed to identify the domains (e.g. housing, public health, education or welfare) and geographical areas actions is likely to have most impact.
- Allocating resources in proportion to need should be used for distribution of public funds rather than competitive bidding.

The Government's Levelling Up White Paper, published in February 2022, brings all Levelling up existing schemes together into 12 "national missions" to tackle regional inequality and sets up a system for measuring progress. These objectives will be put into legislation and overseen by a new levelling-up advisory council. Objectives include:

- Increasing pay, employment and productivity in all areas of the UK
- 40% more public investment in research and development outside the south-east of England
- Eliminating illiteracy and innumeracy by refocusing education spending on the most disadvantaged areas
- Increase the number of people completing high quality skills training
- Bring the rest of the country's public transport "significantly closer" to London standards
- By 2030, provide gigabit-capable broadband and 5G mobile coverage for most households
- Create more first-time homebuyers, and reduce "non-decent rented homes" by 50%
- Narrow the gap of healthy life expectancy between the areas where it is lowest and highest
- Improve "well-being" in every area of the UK

- Increase "pride of place", such as people's engagement in local culture and community
- Reduce homicide, violence and neighbourhood crime, especially in worst-affected areas
- Give every part of England that wants it a devolution deal with more regional powers and simplified, long-term funding

What we're doing to tackle health inequalities locally

There is wide recognition that a system wide approach is required to have an impact on the severity of health inequalities people face. Public health challenges are highly complex, needing targeted and cross-functional responses. Health inequalities are now on the agenda of every integrated care system as they bring together partners from health, social care, the voluntary sector and public health.

Regionally and locally, there are a number of key policies and strategies for tackling health inequalities. In East Sussex, the Health and Care Partnership Plan is the main strategy, and it comprehensively outlines the place-based approach the council and partners are taking to reduce health inequalities. For example, tobacco use is the single greatest behavioural cause of preventable deaths in East Sussex. The diagram below (Figure 24) applies the Labonte model of health (figure 5) and the Population Intervention Model (figure 23) to give an example of local actions that can be taken to reduce this impact.

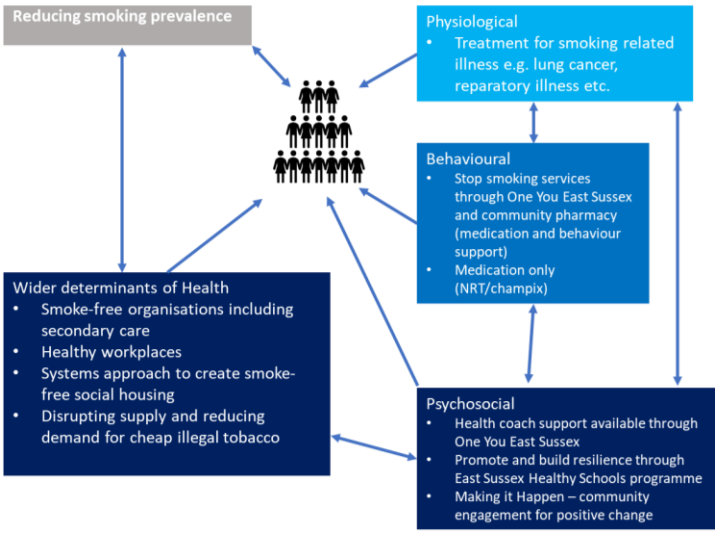
Figure 24: Actions to reduce the impact of tobacco on premature mortality

Cause	Deaths 2019	YHLL
Smoking	1050	22,337
Second-hand smoke	72	1,671
Tobacco	**1098**	**23,442**

How many adults who smoke in East Sussex?
Local Tobacco Control Profiles - Data - PHE – 14.5% in East Sussex which is similar to England (14.3%)

Where are adults who smoke in East Sussex?
Local Tobacco Control Profiles - Data – PHE Highest prevalence is 23% in Hastings and lowest is 11% Wealden

What are East Sussex plans to tackle smoking?
Q2 2021: Begin development of East Sussex Tobacco Control Strategy and agree trajectory for local NHS funded tobacco dependency treatment in secondary care



Source: East Sussex Public Health

NB: YHLL = Years of Healthy Life Lost, is also known as Disability-Adjusted Life Years (DALYs). Data on YHLL/ DALYs is taken from the Global Burden of Disease, with one DALY equivalent to the loss of one year of full health (the sum of the years of life lost to due to premature mortality and the years lived with a disability due to prevalent cases of the disease or health condition in a population).

There are also a number of key policies at a pan-Sussex and national level, including the Sussex Health and Care partnership vision 2025 and Core20PLUS5, which also play

important roles in influencing the work at an East Sussex level. Below are some of the key strategies highlighting how we're approaching health inequalities as a whole system.

Pan-Sussex and national strategies for reducing health inequalities

Tackling neighbourhood health inequalities directed enhanced service (DES)

Primary care networks (PCNs) have been contracted with tackling neighbourhood health inequalities in 2021-2023. From October 2021, PCNs are required to have up-to-date learning disability and severe mental illness registers, recorded ethnicity for all registered patients, as well as have appointed a lead for tackling health inequalities. PCNs are also required to work towards identifying and engaging a population experiencing health inequalities within their area, and to codesign an intervention to address the unmet needs of this population. Delivery of this intervention should commence from March 2022.

Sussex Health and Care partnership vision 2025

Sussex Health and Care Partnership, in collaboration with Brighton & Hove and East and West Sussex, want to support their populations to live longer, healthier lives. The Sussex Health and Care partnership vision 2025 outlines 5 key strategies, one of which is to reduce the gap in healthy life expectancy between people living in the most and least disadvantaged communities. The partnership will focus on four key areas - starting well, living well, ageing well and better care - in order to work towards reducing health inequalities (Figure 25).

Figure 25: Integrated Care System Priorities for Sussex

Source: Sussex Health and Care Partnership, 2021

Tackling health inequalities in Sussex

In response to the pandemic exacerbating health inequalities and the NHS England and NHS Improvement directions, the Sussex NHS Commissioners are working towards addressing and delivery against eight priority targets outlined in the NHS England and NHS Improvement (NHSE/I) Phase-3 letter. These targets are:

- Protect the most vulnerable from Covid
- Restore NHS services inclusively
- Accelerate preventative programmes for those most at risk
- Strengthen leadership and accountability
- Ensure datasets are complete and timely
- Digitally enabled care pathways
- Support those who suffer mental ill health
- Collaborate locally in planning and delivering action

Sussex local transformation plan: children and young people's mental health and emotional wellbeing

The Sussex local transformation plan for children and young people's mental health and emotional wellbeing has a number of key strategies to date aimed at reducing inequalities. These include:

- conducting an Equality Health Impact Assessment to ensure that investments are targeted in areas of greatest need

- ensuring easy access to interpreting and translation for all services
- appointment of a transgender, LGBTQ and inclusion training lead who provides training to all new services and pathways in development
- enhanced analysis of local and national data to help identify and overcome inequalities in access, experience or outcomes in line with the Advancing Mental Health Equalities strategy
- appointment of inequalities participation lead to work across ICS mental health programmes

Key strategies for reducing health inequalities in East Sussex

East Sussex health and care partnership plan

The key goals of the East Sussex health and care partnership plan 2021/22 are to reduce the gap in life expectancy and health life expectancy in the county. In order to do so, a number of actions have been developed to address the wider determinants of health, as well as to tackle the known physiological causes of ill health and premature death as identified in Sussex prevention programmes. These include:

- working with partners to agree on next steps for sustainable community hubs and approaches to community wellbeing
- developing a system approach to tackling loneliness and social isolation
- using insights gained from Hastings and St Leonards PCN and the Sussex Population Health Management Accelerator programme to help inform the growth of Population Health Management capability in East Sussex
- continuing to develop the East Sussex social prescribing model
- ensuring that all local plans and programmes have a focus on health inequalities and have specific health inequalities priorities, including
    - working with the local community to develop a joint agreement on our understanding of population health and health inequalities
    - ensuring personalised care and support approaches are embedded in all necessary pathways
    - joining up our approach as employers and service providers for the benefit of the social and economic wellbeing of our communities

The plan also identifies the need to collaborate and work with a number of key partners in order to fulfil the actions outlined above. This includes collaborating with the local community, Voluntary, Community and Social Enterprise (VCSE) organisations and local PCNs.

East Sussex County Council equality and inclusion strategy

The equality and inclusion strategy is a three-year strategy that sets out the councils commitment to promoting equality and diversity across all services and within the workforce. The strategy has five priority areas which are:

- know our communities,
- have inclusivity at the heart of service development and strengthen community engagement,
- create a safe, fair and inclusive work environment,
- use robust data collection from service users and use of data for equality analysis,

- and strengthen adult social care and health (ASCH) staff practice and knowledge on all aspects of equality and human rights as they connect with ASCH work.

Health in All policies

Health in All policies were defined at the 8th Global Conference on Health Promotion in Helsinki in 2013. It was agreed that "health in all policies is an approach to public policies that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts, in order to improve population health and health equity". It recognises that the health of individuals is not the responsibility of the health sector alone, but rather that there are many, wider determinants of health. The approach focuses heavily on cross-sector action and collaboration to address wider determinants of health to reduce health inequalities in a systematic way.

What you can do to tackle Health inequalities locally

There are a number of key actions partners within the system can take to tackle health inequalities. In addition to national guidance on Place-based approaches and Taking a whole-systems approach to health inequalities, there are a number of tools to support action. For example:

Health Equity Assessment tool (HEAT)

A tool for professionals across the public health and healthcare landscape to systematically assess health inequalities and equity across their service or work, and to identify any subsequent action required. The tool provides an easy-to-follow template that can be applied flexibly to suit different work programmes and services. It can be easily embedded where appropriate into existing systems and processes, including business planning, annual service reviews or commissioning cycles.

Equality and Health Inequality Impact Assessment

Similar to HEAT, this resource assists providers of health services to consider equality and the potential impact of policy, practice and programmes of work on groups with a protected characteristic. This document in available on request from england.eandhi@nhs.net

Health Inequalities Impact Assessment (HIIA) Toolkit

The toolkit helps to assess the impact on people of applying a proposed, new or revised policy or practice. HIIA goes beyond the public sector's legal duty to assess impact in relation to the Equality Act 2010, as HIIA looks at the impact on health inequalities; people with protected characteristics;

human rights; and socioeconomic circumstances.

Health and Environment in All Policies

This is a key resource for tackling health inequalities locally, which has been developed off the back of local government guidance. It is a collaborative approach to improving the health of all people by incorporating health considerations into decision making across

sectors, policy and service areas, and addressing the wider determinants of health. It will be used as a mechanism to get health into place, to have healthy and sustainable policies and guide decision making. This approach will champion the use of health impact assessments and require projects, policies and programmes of work to consider health impacts as well as mitigate against negative health impacts. An example of local implementation of health and environment in all policies is the "spatial planning for health agenda" which is working to create healthier built and natural environments.

Links to main evidence sources

What are health inequalities?

- NICE Guidance: Health Inequalities and population health
- Marmot review Report – Fair Society, Healthy Lives
- The Marmot Review 10 Years on
- The Kings Fund – What are health inequalities?
- Local Government Association Health Inequalities Hub
- Deloitte: Identifying the gap: understanding the drivers of inequality in public health

How has COVID impacted health inequalities?

- Unequal pandemic, fairer recovery
- Health Profile for England 2021
- COVID-19 Health Inequalities Monitoring for England (CHIME)
- Wider Impacts of COVID-19 on Health (WICH)
- Build back fairer: the COVID Marmot Review

Where can I get information on health inequalities in East Sussex?

- http://www.eastsussexjsna.org.uk
- https://www.eastsussexinfigures.org.uk/webview/welcome.html
- https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthinequalities
- https://fingertips.phe.org.uk/profile/wider-determinants
- https://fingertips.phe.org.uk/profile/inequality-tools
- https://fingertips.phe.org.uk/profile-group/marmot

What tools and resources are there to support reducing health inequalities?

- Public Health England: Addressing Health Inequalities through collaborative action
- NHS England: Reducing Health Inequalities resources
- Local Government Association: Health Inequalities Hub
- Public Health England: Health Equity Assessment Tool (HEAT)
- Public Health England: Reducing health inequalities: system, scale and sustainability
- Public Health England: Tools to support 'Place-based approaches' for reducing health inequalities
- NHS England: The role of businesses in reducing health inequalities

1 Public Health England (2017) Reducing health inequalities: system, scale and sustainability https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/731682/Reducing_health_inequalities_system_scale_and_sustainability.pdf

2 Kings Fund (2020) What are health inequalities? https://www.kingsfund.org.uk/publications/what-are-health-inequalities#:~:text=They%20include%20income%2C%20education%2C%20access,fundamental%20cause%20of%20health%20inequalities.

3 Institute of Health Equity (2010) Fair Society, healthy lives https://www.local.gov.uk/marmot-review-report-fair-society-healthy-lives

4 Kings Fund (2020) What are health inequalities? https://www.kingsfund.org.uk/publications/what-are-health-inequalities#pathways

5 Dyson A, Hertzman C, Roberts H, Tunstill J and Vaghri Z (2009) Childhood development, education and health inequalities. Report of task group. Submission to the Marmot Review

6 Commission on Social Determinants of Health (2008) CSDH Final Report: Closing the gap in a generation: Health 12 equity through action on the social determinants of health. Geneva: World Health Organization. https://www.instituteofhealthequity.org/resources-reports/commission-on-social-determinants-of-health-closing-the-gap-in-a-generation

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8 Marmot, M (2010) Fair Society, Healthy Lives: The Marmot Review. Institute of Health Equity https://www.local.gov.uk/marmot-review-report-fair-society-healthy-lives

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