Tackling Health Inequalities

Contents

Introduction:

Defining 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]

This briefing outlines what we mean by health inequalities and why they're important, what drives health inequalities, what health inequalities look like in East Sussex, how we should be tackling health inequalities, and what we are doing about them locally.

A health inequalities guide has been developed as part of this work to help you identify what health inequalities there may be within your area of interest in East Sussex. Please see accompanying link on the JSNA website. Has been developed as part of this work to help you identify what health inequalities there may be within your area of interest in east Sussex. **Please see accompanying link on the JSNA website.**

Summary:

- The factors contributing to our health are complex and interact to the benefit or disadvantage of people or groups.
- Improvements in healthy life expectancy in East Sussex are stalling and are now below pre-Covid levels
- There is a gap of nearly 20 years in healthy life expectancy for both men and women between the most and least deprived areas
- There are significant inequalities in how long people are living and how much of their life they live in good health. A woman in Central St Leonards might expect to live 11 years in poor health before they retire, compared to a woman in Frant and Groombridge experiencing 9 years of their retirement in good health.
- We all need to be aware that health inequalities will be impacting on all areas of work supporting residents in East Sussex.

Recommendation:

A call to action: health inequalities need to be considered in everything we do.

IDENTIFY health inequalities in your area of work and address any data and knowledge gaps

PLAN what needs to be done

TAKE ACTION, working individually and collectively - EVERYONE must DO something

REFLECT on your impact and share your learning

Executive Summary

There are 4 domains of health inequality:

OHID, 2021

The factors contributing to our health are complex and interact to the benefit or disadvantage of people or groups.

Individuals may experience many of the factors influencing poor health at the same time, leading to poorer health outcomes.

OHID, 2022

Wider factors influencing health inequalities since 2010

Marmot et al 2021

Work
Transport
Money / Resources

main drivers of health inequality

Environment
Housing
Community

Marmot et al 2010

Since 2010 in the UK:

People can expect to live more of their lives in poor health

Improvements in life expectancy have stalled

The health gap between wealthy and deprived areas has grown

Marmot et al 2020

COVID created a 'perfect storm' of existing inequality and disease

leading to higher rates of infections and death among the most disadvantaged people

Marmot et al 2021

78,400 (14%)

of 550,720 East Sussex residents

live in Core20 neighbourhoods (the most deprived 20% of neighbourhoods nationally)

Eastbourne	Hastings	Lewes	Wealden	Rother
20,200	39,500	3,000	6,100	9,600

Public Health Intelligence 2024

The gap between the highest and lowest life expectancy in East Sussex at MSOA* level is:

10.1 years females

12.7 years males

(*MSOA: an area of approx. 8,000 people)

ONS, 2018-20

Average life expectancy in East Sussex is:

83.4 years females (England 83.1 years)

79.9 years males (England 79.1 years)

ONS, 2021-23

In East Sussex:

Biggest causes of death

Heart Disease + Alzheimers

Alzheimers accounts for 1.5x the number of deaths caused by heart disease

Public Health Mortality Files, 2025

Heart Disease + Alzheimers

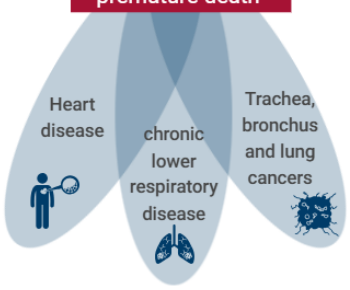
account for 1.75x more deaths than the next most common causes:

stroke + chronic lower respiratory disease

Public Health Mortality Files, 2025

In East Sussex:

Biggest causes of premature death



Public Health Mortality Files, 2025

CVD + CANCER

Are the biggest health contributors to the life expectancy gap between most and least deprived areas for both men and women

Institute of Health Metrics Evaluation, GBD 2023

Tobacco

Is the greatest risk factor for both deaths and years lived in ill health.

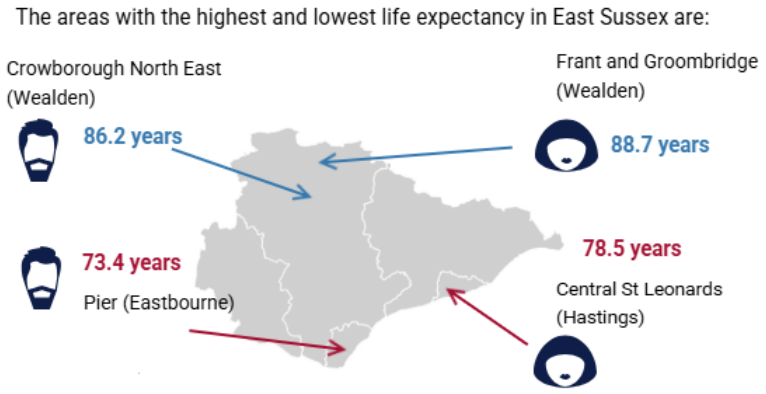
Smoking prevalence is declining, but more slowly in more deprived communities → the gap in prevalence between the most and least deprived areas has increased

Institute of Health Metrics Evaluation, GBD 2023

Life expectancy

In East Sussex was improving until 2013-15, then stalled until 2018-20, and has dropped since the pandemic

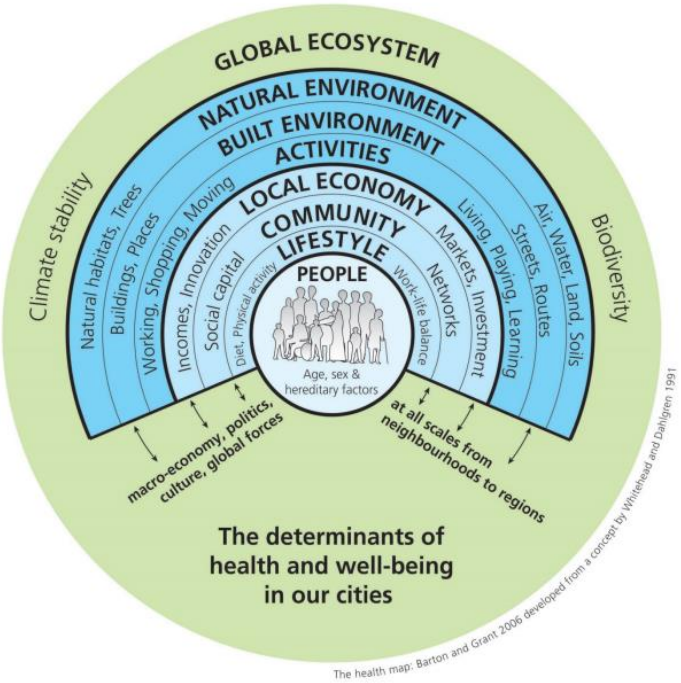
It currently remains lower than pre-pandemic levels



Section 1: Why are health inequalities important?

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 Health Map: an integrated conceptual framework of human ecosystems with lifestyles and health at the core

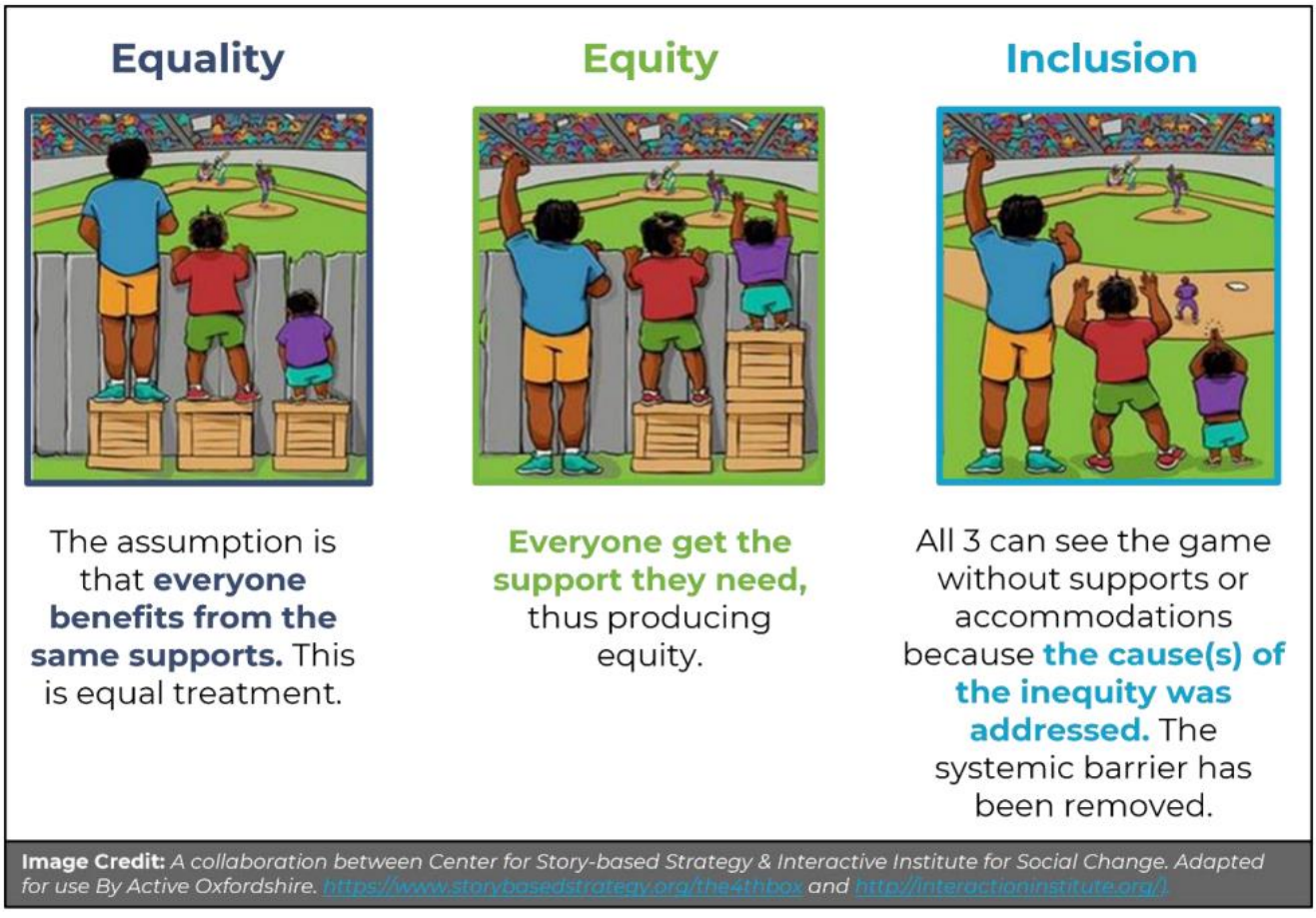


Source: Barton and Grant, 2006, developed from Dahlgren and Whitehead, 1991.

Ill-health and death are unequally distributed among the population of Britain. These inequalities are attributable not only to unequal health provision, but to other social inequalities and structural and environmental factors which are constraining people's behaviour and opportunities for good health. Differences in these 'determinants of health' are largely preventable. This means that the poorer a person's circumstances, the more likely they are to spend more of their lives with disability and poor health and to die prematurely:[3]

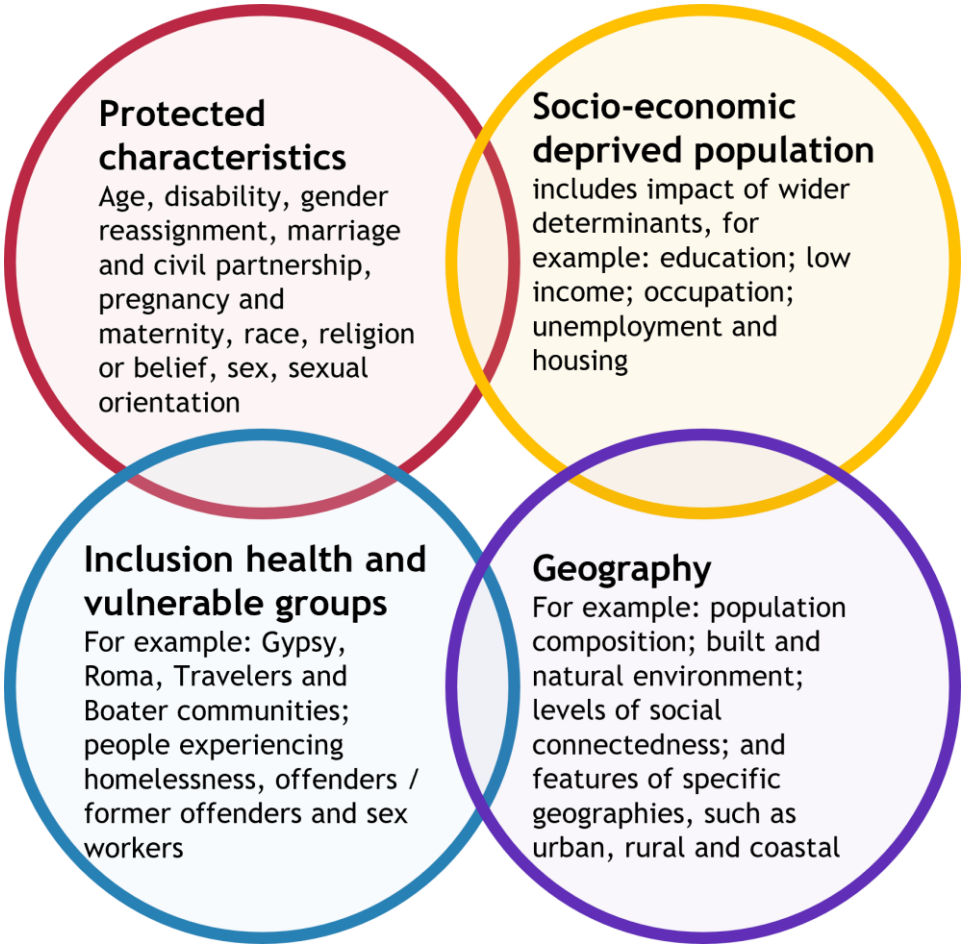
What are health inequalities?

Equality is the even distribution of resources across all people. Equity, on the other hand, is the distribution of resources based on need.



Health inequalities in England are often described by people's experiences in four key areas: socio-economic factors, geography, specific characteristics including those protected by law, and socially excluded groups (figure 2).

Figure 2: Domains of health inequality



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

Inequalities in these factors are inter-related, interacting with each other to benefit or disadvantage different people or groups. 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]

For example, inequalities in access are recognised within health and care service provision. 2021 government guidance highlights Inclusion health **'as a 'catch-all' term used to describe people who are socially excluded, typically experience multiple overlapping risk factors for poor health (such as poverty, violence and complex trauma), experience stigma and discrimination, and are not consistently accounted for in electronic records (such as healthcare databases).** [5] These experiences frequently lead to barriers in access to healthcare and extremely poor health outcomes. People who experience these risk factors underuse some services, such as primary and preventative care, and often rely on

emergency services such as A&E when health needs become acute.

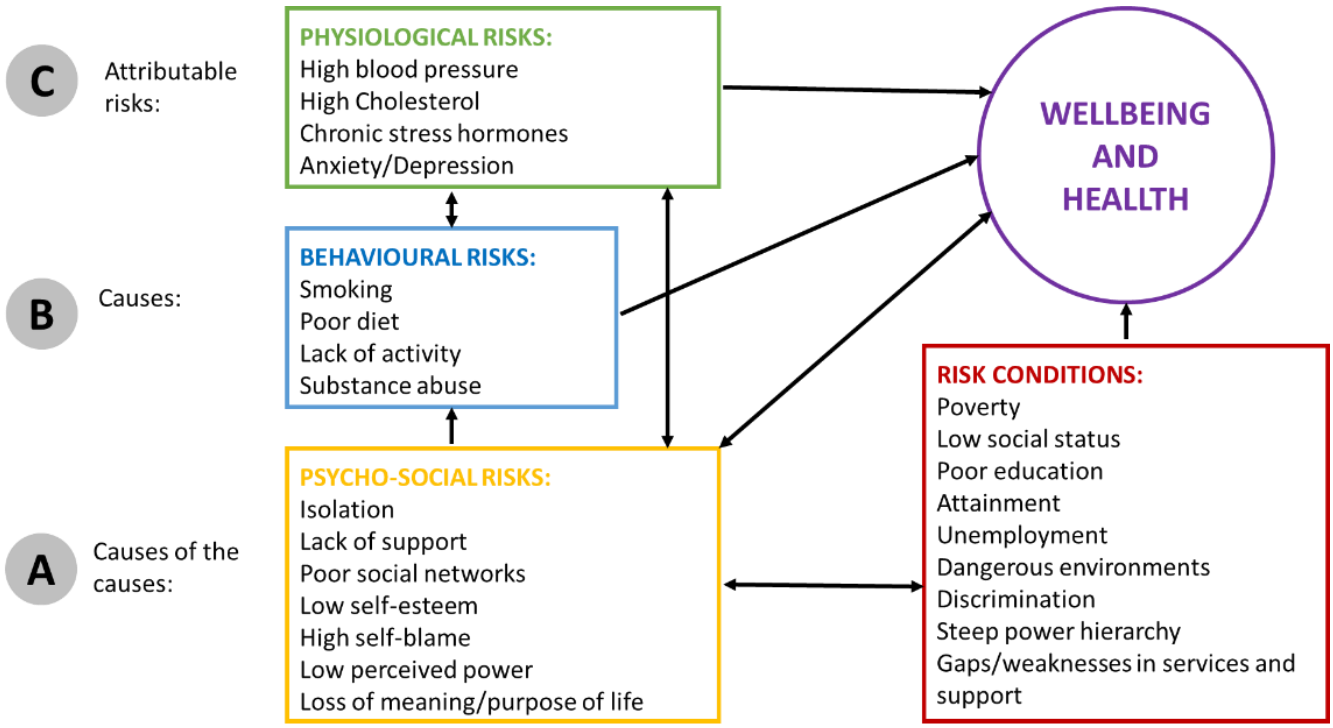
Barriers to accessing health and care services may include: having difficulty understanding and navigating the system; having previous negative experiences or feeling marginalised or stigmatised; not speaking the language or being able to read or write, and being afraid of punitive action after accessing services. At the same time, services may not be prepared to deal with the complexity of these issues.[5] Inclusion health is an approach to develop and adopt inclusive practice seeking to empower patients, develop health literacy, and help capture information so that disadvantaged groups having difficulty in accessing health care are included in healthcare records.[6]

What affects 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." [7]

Attributable risk factors for health inequalities are the conditions that people may present with which can directly lead to long term illness (e.g. high blood pressure). People's behaviours, such as smoking, poor diet, physical inactivity and high alcohol consumption, are the main major causes of preventable ill health, but these behavioural risks are influenced by a complex interaction between many socio-economic, cultural and environmental factors. 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. Figure 3 illustrates the complex relationships between attributable risk factors for health and wellbeing, and the factors causing and influencing these risks.

Figure 3: Patterns of risk affecting health and wellbeing: Labonte Model of Health



Source: Public Health England, 2017

The 2010 Marmot review described these inequalities as occurring across a social gradient of health, and as accumulating throughout a person's life depending on their circumstances. A social gradient of health describes a systematic relationship between deprivation and life expectancy, meaning that the lower a person's social position, the worse their health. This social gradient on health inequalities is also reflected in other areas of someone's life, for example, educational attainment, employment, income, quality of neighbourhood.

This kind of disadvantage starts before birth and accumulates throughout life. Social and biological influences on development start in pregnancy, and from birth an individual is exposed to social, economic, psychological and environmental experiences, which change as they progress through life (across the life-course). 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.

What are the main drivers of health inequalities:

The Health Foundation have identified the main drivers of health inequalities as money and resources, work, transport, housing, neighbourhoods and surroundings, and family, friends and communities (figures 4 and 5).

Figure 4: Main drivers of health inequalities

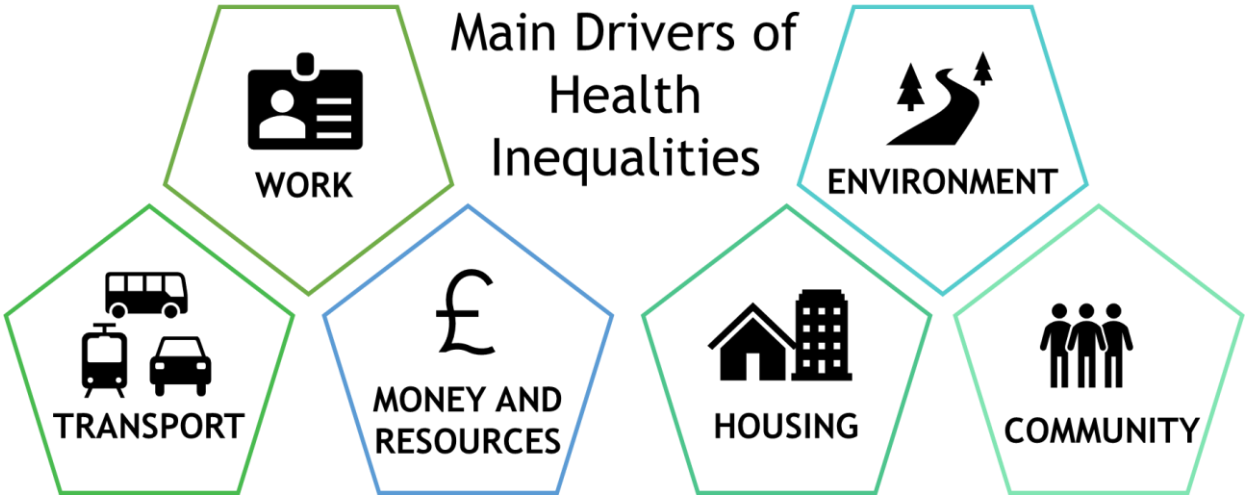


Figure 5: Key statistics on the main drivers of health inequalities as seen nationally

Transport:

- 1,190 early deaths prevented per year if averages miles walking/cycling increased across England to the same level as in the regions with the highest rates
- 3x more likelihood of accessing public services (e.g. education, food shops, and healthcare) for those rating transport as good compared to those rating it as poor.

Work:

- 5.1 years added to male healthy life expectancy for each 10% higher the employment rate is in an area
- 11% employees report poor health, with lower self-reported health in employees with low job security and satisfaction
- 1 in 3 employees experience two or more negative aspects of job quality

Money and resources:

- £1,000 increase in household income is associated with a 0.7 year increase in female healthy life expectancy
- 32% of people with the lowest income report less good health, compared to 11% of people with the highest income
- 14.5 million people in the UK (22%) live in poverty

Housing:

- 28% private renters in non-decent homes report less good health, compared to 22% in decent homes
- 1 in 3 households in England experience at least one housing problem
- 26% parents moving home 3+ times reported poor health compared to 14% who did not move
- 2x children in poverty were likely to have moved 3+ times compared to children not in poverty

Neighbourhood and surroundings:

- 9x less access to green space on average in more deprived areas compared to less deprived areas
- 28,000-36,000 lives estimated to have been cut short but air pollution exposure, with exposure linked to deprivation and ethnicity

Family, friends and community:

- 1 in 10 18-24 year olds often or always feel lonely - 2x as many as the population as a whole

Source: Adapted from Health Foundation, 2010

How have health inequalities changed in recent years:

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, with health inequalities getting 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

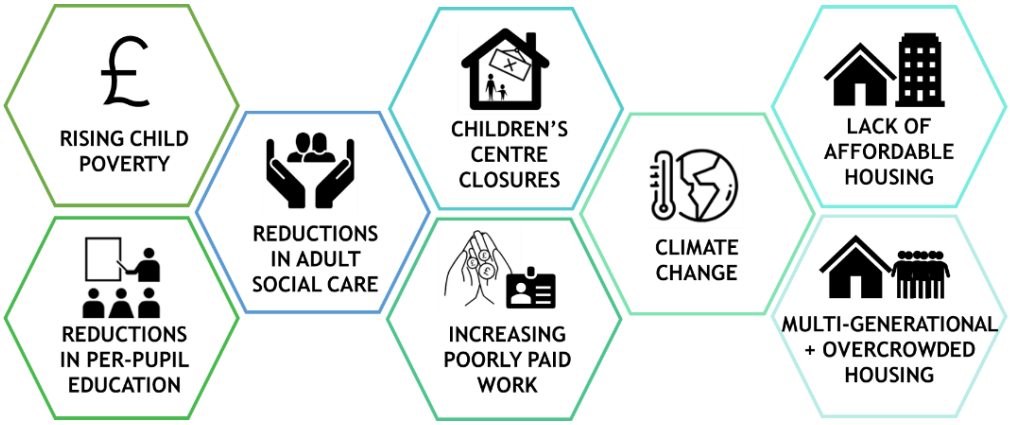
(deaths in people under the age of 75 years). The UK has seen improvements in life expectancy every decade in the last century, up until the decade prior to the pandemic when life expectancy improvements stalled, and health inequalities were growing.

In 2024, the Institute of Health Equity (IHE) published a report looking at health inequalities and life expectancy at a local level. The report highlights that life expectancy at birth in England has been increasing at a significantly slower rate since 2011 than in previous decades and has stalled in more recent years. However, inequality in life expectancy and healthy life expectancy varies across the country; with women in the most deprived neighbourhoods seeing a fall in life expectancy even before the pandemic. We are also seeing a widening of the north/south gap, with inequalities in life expectancy and healthy life expectancy greatest in the North East, and least in the 4 regions of the South and East.

At a Local Authority level, there have been significant increases in inequalities in life expectancy (a widening gap between the most and least well off) in 17 authorities, and no statistically significant decrease in inequality in life expectancy (narrowing of the gap between most and least well off) for either men or women in any English Local Authority. The report identifies the impact of an average 34% reduction in local authority spending power from central government since 2010/11 on the funding of many services which affect the drivers of health inequalities e.g., housing, education and social care. Spending cuts were found to be highest in the areas with lower life expectancy and more health inequalities.

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 particular damage caused by:

Figure 6: Wider factors influencing health inequalities since 2010



Key changes in health inequalities since 2010 include:

The impact of widening inequality is that one million people are living shorter lives than they should, and the IHE calls on the government to urgently implement the evidence-based recommendations in the 2010 and 2020 Marmot Reviews and the 2020 COVID review which have identified how to improve health and reduce inequalities in the long term.

How has COVID impacted on health inequalities?

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 2021 Unequal pandemic, fairer recovery report warned that COVID-19 created a 'perfect storm' of existing inequality and disease, leading to higher rates of infections and death among the most disadvantaged people, highlighting:

- 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.

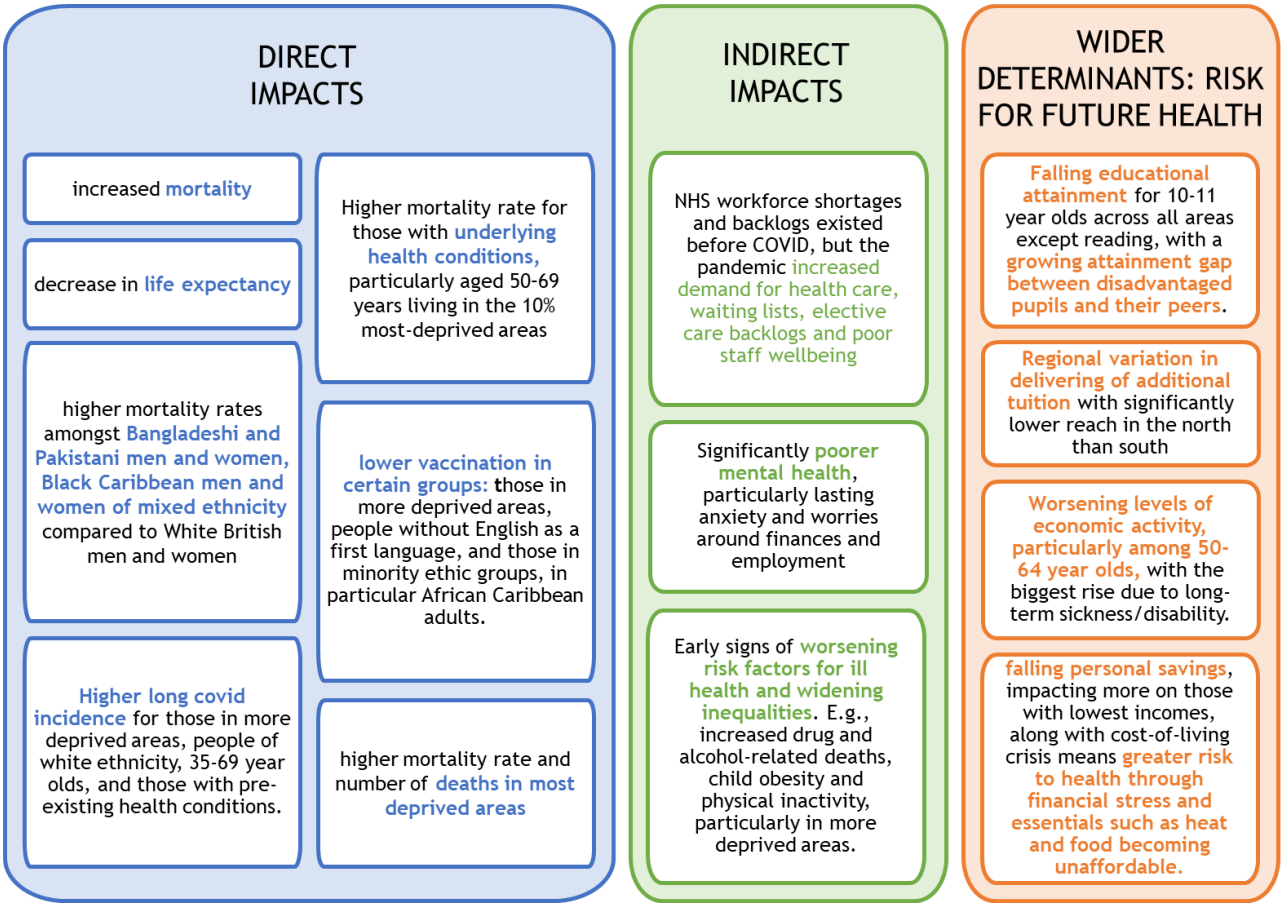
- the unequal effect of the pandemic on some groups, including young people, disabled people, ethnic minority communities, care home residents, prisoners, homeless people and people experiencing sexual exploitation.
- the type and quality of work, housing conditions, and access to financial support to 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 2022 follow-up report The continuing impact of COVID-19 on health and inequalities, looked at the impact on health inequalities a year after the intial inquiry. Key findings were that:

- while the overall number of deaths was significantly lower, inequalities in COVID-19 mortality persist with mortality rates 3 to 4 times higher in the most deprived areas.
- Vaccination was key to reducing mortality rates, but uptake was still lower among those in poorer areas and some ethnic minority groups
- The significant deterioration in mental health during the first year of the pandemic has been reversing but has not yet returned to pre-pandemic levels, particularly in terms of anxiety, and amongst young women.
- Whilst a large rise in unemployment was avoided through schemes such as furlough, long-term health conditions are keeping a significant number of people out of work
- The COVID-19 education gap in terms of learning lost between those from richer and poorer backgrounds during the pandemic has not been addressed. A cohort of children face significant risks to their long-term health and living standards.

The report looked at direct impacts, indirect impacts and wider-determinants of COVID (more detail in appendix 1).

Figure 7: Direct impacts, indirect impacts and wider-determinants of COVID

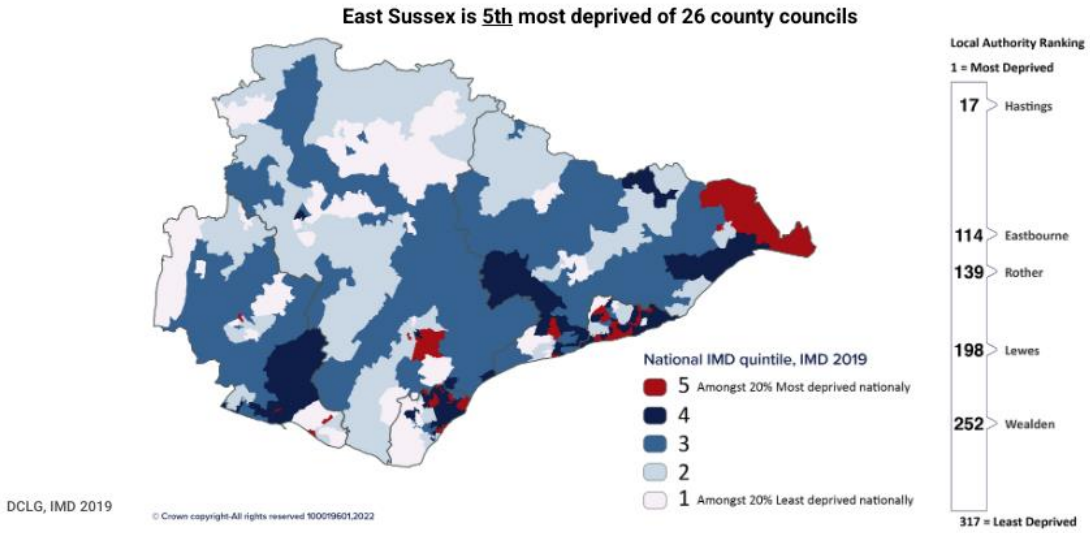


These findings build on the growing evidence based of disparities in health, and wider outcomes of the COVID pandemic in the UK, with key analysis provided by the Local Government Association's Health Inequalities Hub, Build Back Fairer: The COVID-19 Marmot Review, the 2021 Race Disparity Office report on progress to address COVID-19 health inequalities, and the 2021 Joseph Rowntree Foundation (JRF) report which also highlights years of rising poverty before the pandemic, and that 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 disproportionate impact of COVID-19 has also been seen in East Sussex: East Sussex in Figures -COVID-19

Section 2: What do health inequalities look like in East Sussex:

Local demographics



11.7%

Identify as belonging to an ethnic minority group
(16.5% in England)

Census 2021

20%

of people have their day-to-day activities limited due to disability
(17% in England)

Census, 2021

550,720

Residents in 2022

ONS MYE, 2024

286,211/ 52%

Females

264,509/ 48%

Males

ONS MYE, 2024

3.3% Identify as LGBT+

Lesbian, gay, bisexual, transgender & other sexual & gender identities. (3.2% in England)

Census, 2021

3/4 Residents live in urban areas

74% Urban city & town

15% Rural village & dispersed

11% Rural town & fringe

ONS, 2019, census 2011

22,474 People into the county

18,518

People out of the county

ONS, 2020

More detail on the East Sussex population can be found in the East Sussex Life Course Summary and in the JSNA Priorities Summary 2024 Compared to England, East Sussex has

- a much older age profile with an increasingly ageing population,
- a less ethnically diverse population,
- A higher proportion of people with a long-term limiting illness or disability.

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. LSOAs 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 in all Districts and Boroughs since 2015, although there is variation across the county. 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.

Figure 8: Map of deprivation in East Sussex, 2019

(darker areas = more deprived)

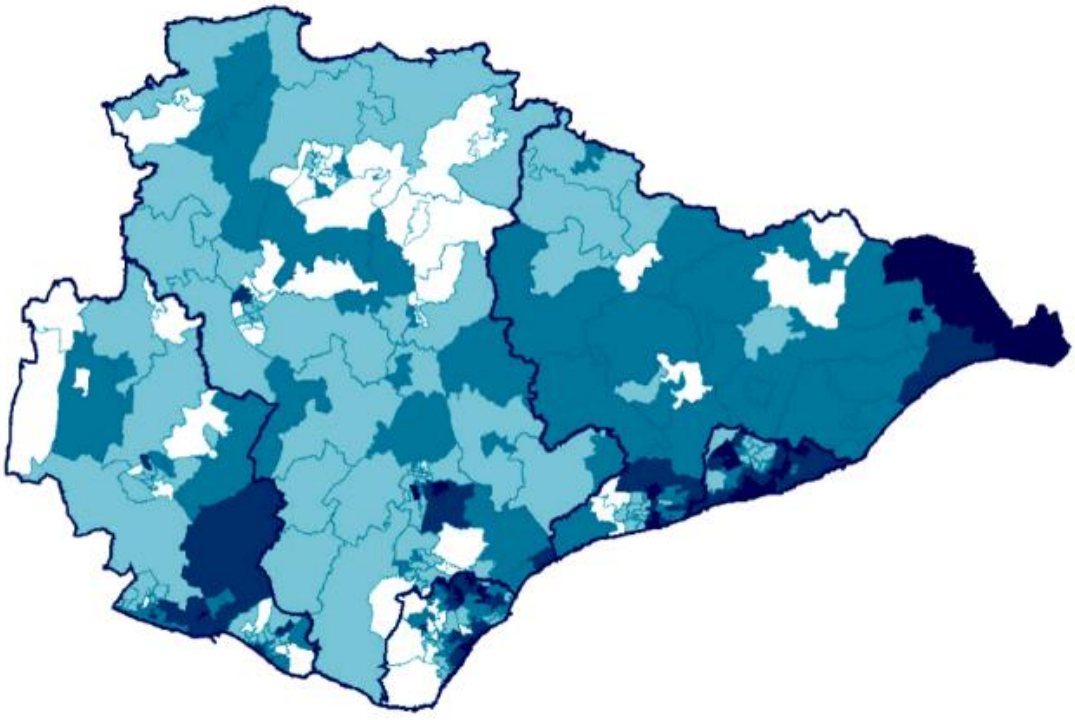


Table 1: Percentage of population in each quintile for East Sussex, Census 2021

National deprivation quintile	Eastbourne	Hastings	Lewes	Rother	Wealden	East Sussex
1 (most)	20%	43%	3%	10%	4%	14%
2	31%	30%	20%	20%	3%	19%
3	26%	14%	24%	35%	27%	26%
4	14%	12%	36%	26%	35%	26%
5 (least)	10%	0%	16%	9%	31%	15%

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, 43% of the population live in areas in the ***most*** deprived 20% nationally, while in Wealden only 3% are in the most deprived quintile. Conversely, in Wealden 31% of the population live in areas in the ***least*** deprived 20% nationally compared to 0% of the population in Hastings (Tabel 1).

Measures of inequality

The most common measures of inequality are life expectancy, healthy life expectancy and premature mortality. These are often looked at in relation to deprivation, age, gender and geography to explore the social gradient of health inequalities.

Inclusion health is an umbrella term used to describe people who are socially excluded and typically experience multiple interacting risk factors for poor health. These can include stigma, discrimination, poverty, violence, and complex trauma. For example, someone who is alcohol dependent may also be homeless resulting in vulnerability, limited opportunities, very poor health and reduced life expectancy. Risks may also build up over the life course. For example, adverse experiences in childhood can lead to vulnerabilities and health needs in both childhood and later life. Inclusion health groups therefore require an explicit, tangible focus in system efforts to reduce healthcare inequalities.[8]

While multiple other factors influence our health and wellbeing, the health data available for many are limited, and therefore this briefing 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.

Table 2: Summary table of key measures

Life expectancy

Measure	Gender	Highest	Lowest	Gap	What this tells us
by District and Borough (2021-2023) by MSOA (2016-2020)	Males	81.9 yrs (Wealden)	76.7 yrs (Hastings)	5.2 yrs	Indicates size of the gap in East Sussex
	Females	84.9 yrs (Lewes)	80.9 yrs (Hastings)	4 yrs	
	Males	86.2 yrs (Crowborough North East)	73.4 yrs (Pier)	12.7 yrs	Indicates size of the gap in East Sussex and identifies areas with lowest LE for potential targeting
	Females	88.7 yrs (Frant and Groombridge)	78.5 yrs (Central St Leonards)	10.1 yrs	
Biggest contributors to LE Gap (2021-22)	Males	Circulatory (23%),			Identifies causes of death that contribute the most to LE gap locally for potential targeted work
		Cancer (18%)			
	Females	Cancer (25%), Circulatory (23%)			

Healthy life expectancy

Measure		Highest	Lowest	Gap	What this tells us
by MSOA (2009-2013)	Males	Frant and Groombridge (73.3)	Central St Leonards (53.9)	19.4	Indicates size of gap and helps identify areas to target to increase years spent in good health

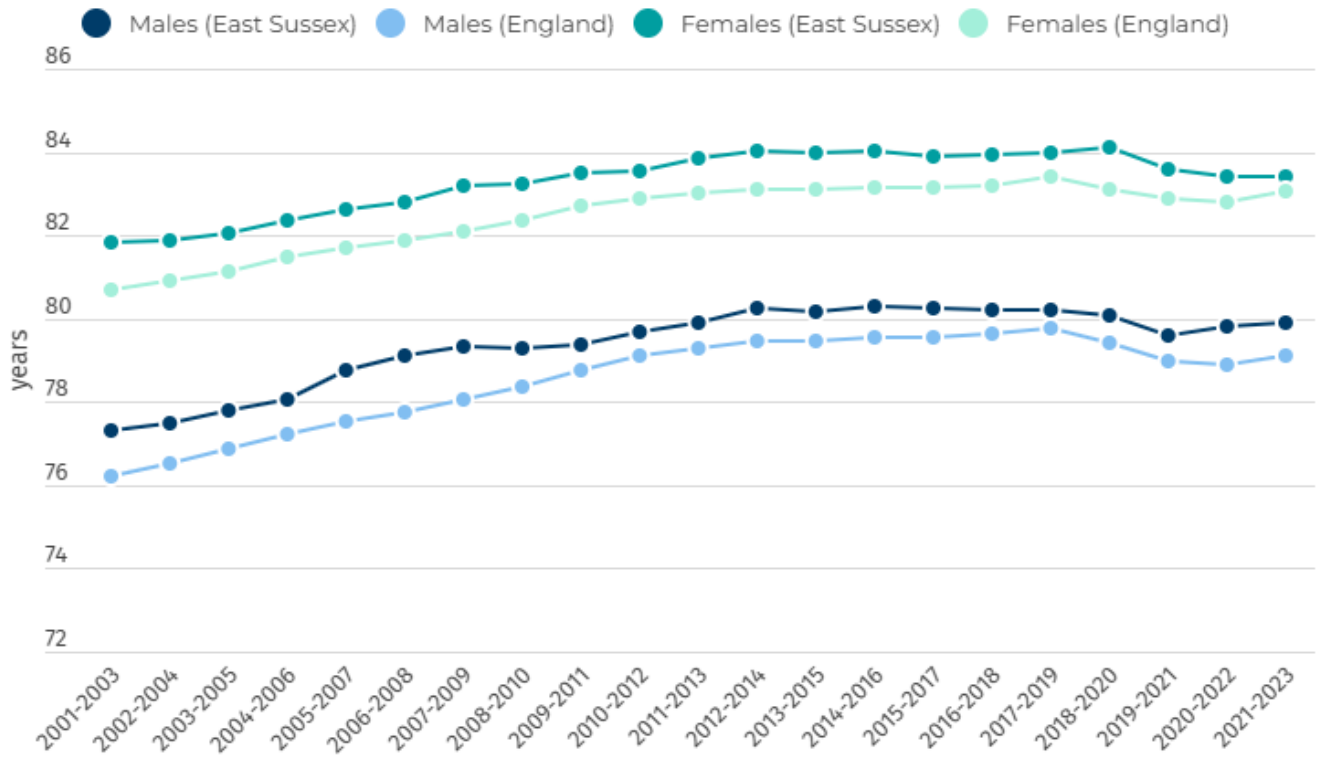
	Females	Frant and Groombridge (74.7)	Central St Leonards (55.5)	19.2	
Gap: most and least deprived areas (2021)	Males	71.5	56.6	14.9	Shows the inequality in years spent in good health
	Females	71.2	58.1	17.1	

Life expectancy (LE)

In East Sussex, life expectancy (LE):

- In 2021-23 LE was 83.4 for females, and 79.9 for males,
- LE is higher for both males and females compared to England,
- LE has been improving over time but then stalled, dropped due to the pandemic but increased slightly over the last period

Figure 9: Life expectancy at birth 2001-03 to 2021-23, East Sussex and England



Please note the axis does not start at 0

District and Borough by Sex

Life expectancy:

- is lowest in Hastings followed by Eastbourne,
- is highest in Lewes and Wealden,

At district/borough level

- ranges by 5.2 years for males (76.7 in Hastings to 81.9 in Wealden),
- ranges by 4 years for females (80.9 in Hastings to 84.9 in Lewes),
- Increased for males in 2021-2023 in Rother and Wealden, and decreased slightly in Lewes,
- Broadly stayed the same for females in 2021-23 all district/boroughs

Figure 10: Male life expectancy at birth 2001-03 to 2021-23, District and Borough

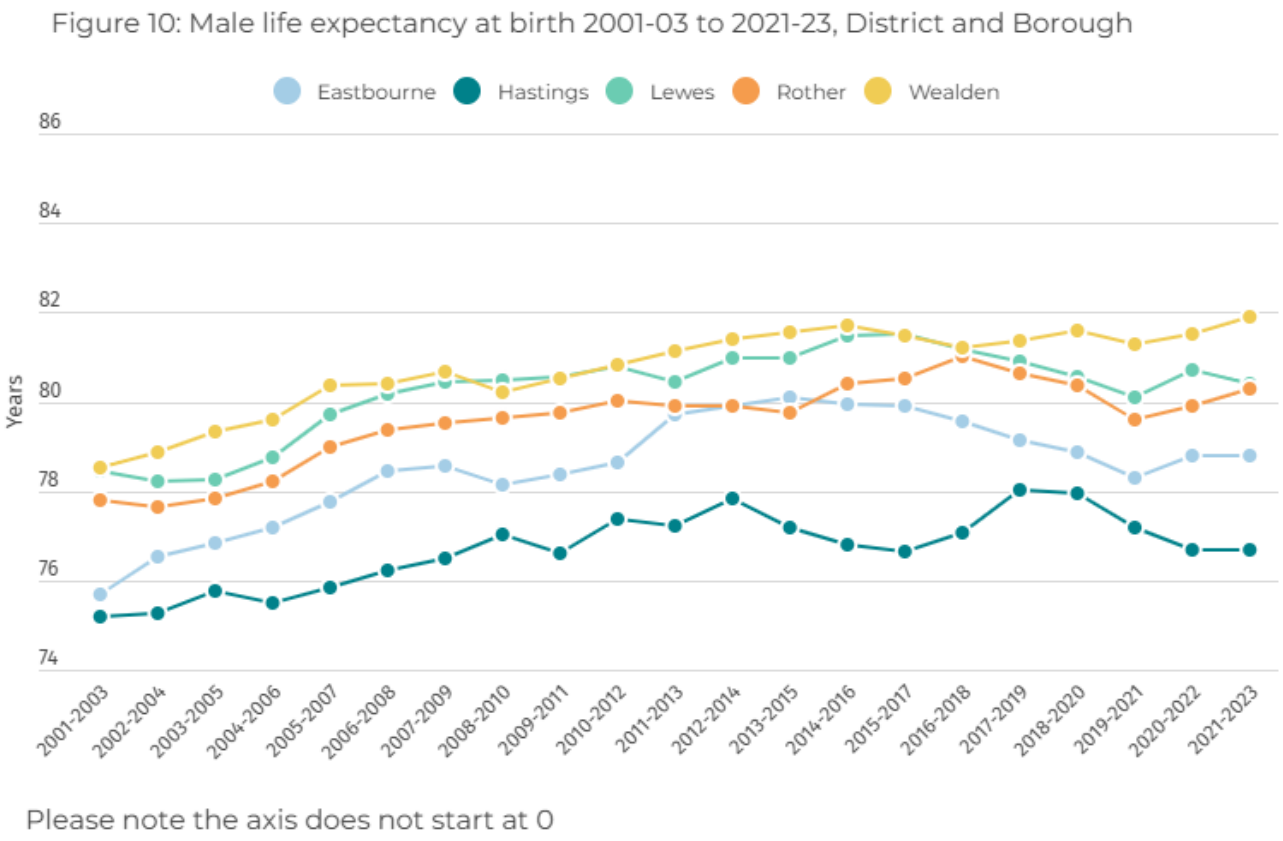
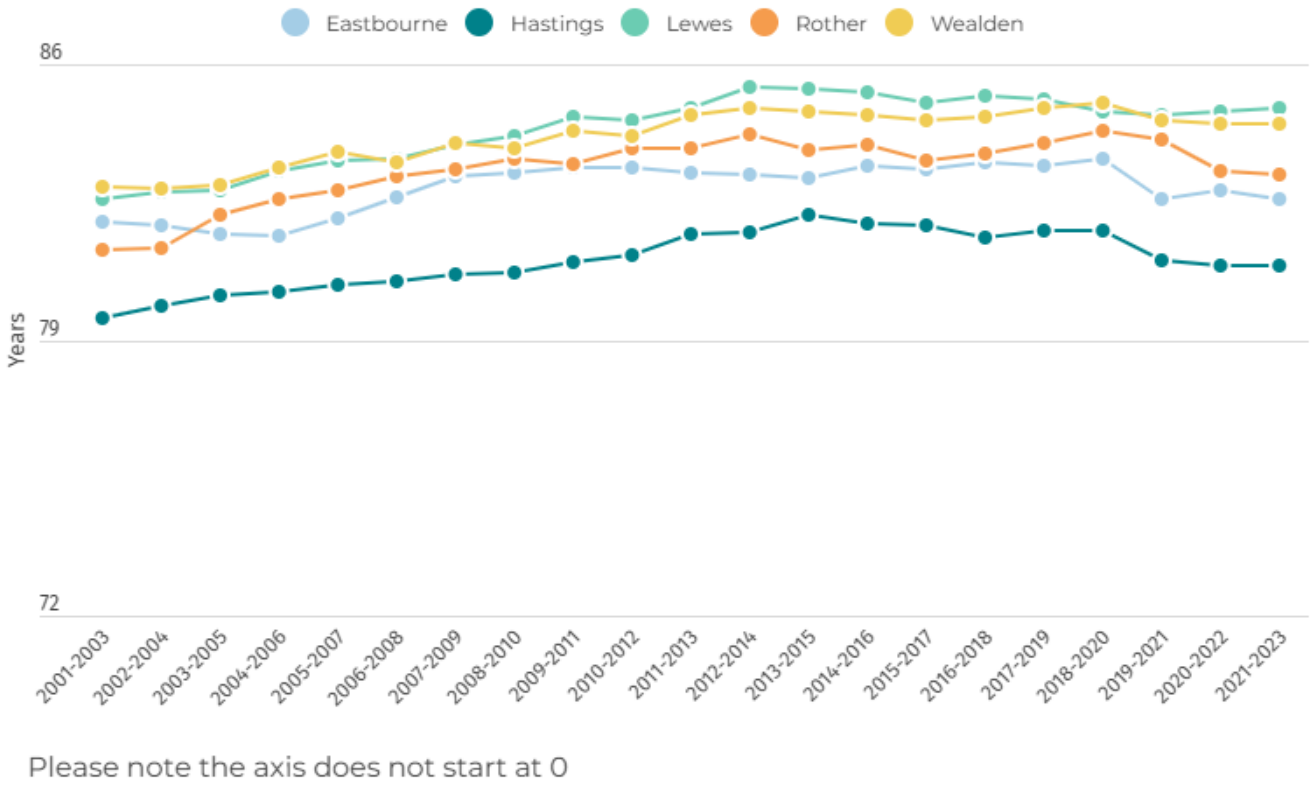


Figure 11: Female life expectancy at birth 2001-03 to 2021-23, District and Borough

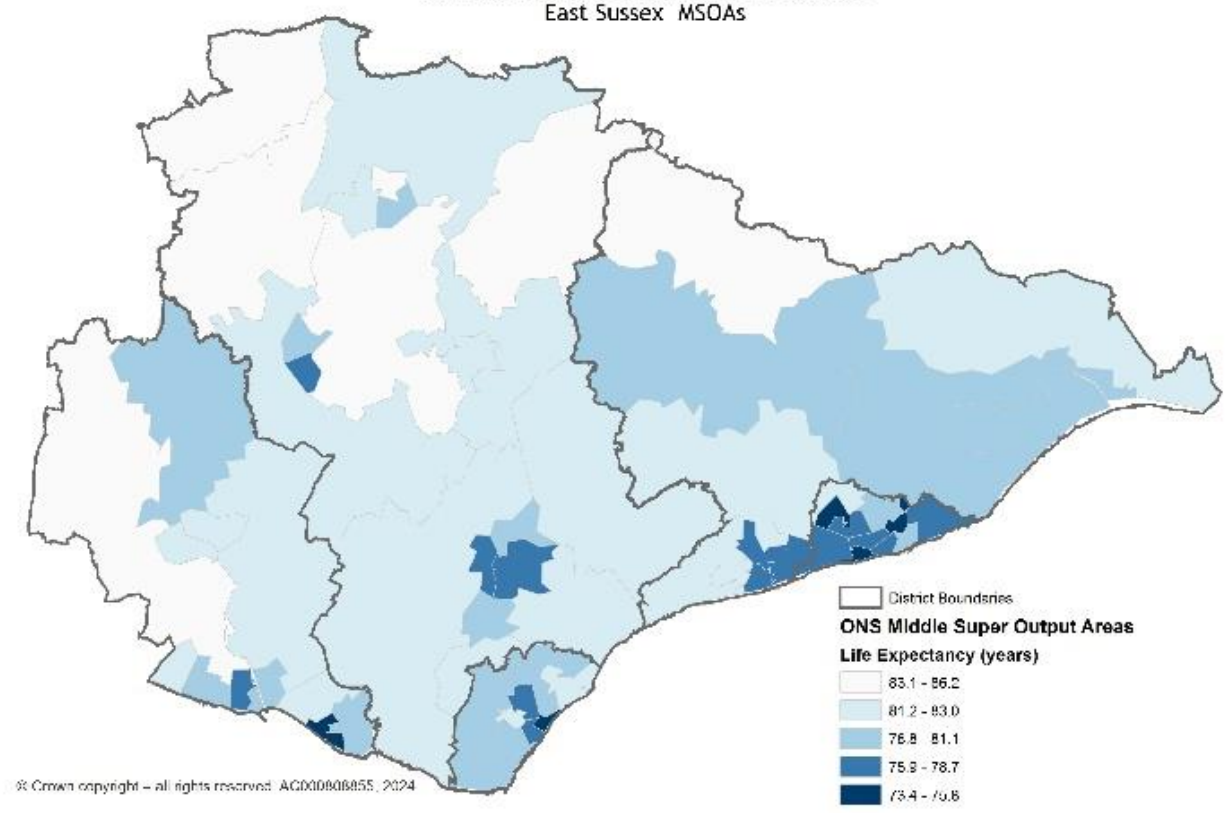


Please note the axis does not start at 0

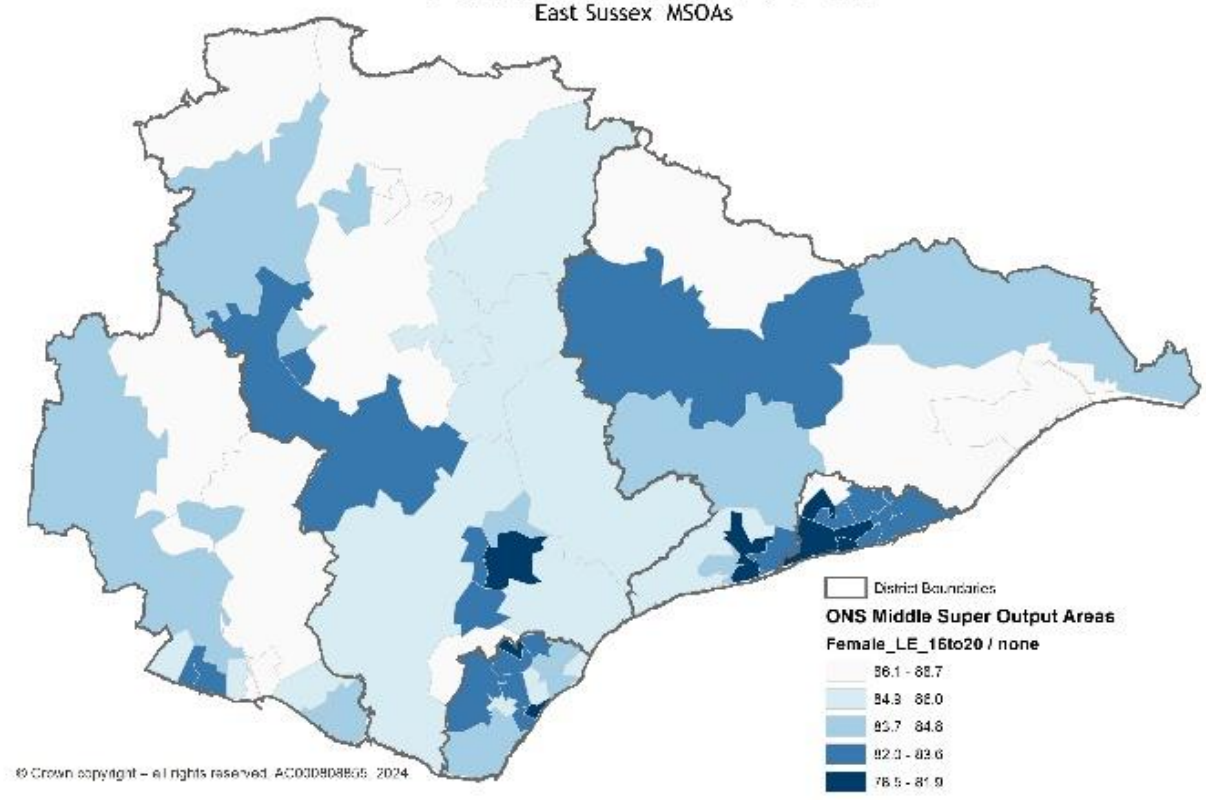
- at MSOA level in East Sussex (areas of around 8,000 people) there is:
- a gap of 10.1 years for females between highest and lowest LE,
- a gap of 12.7 years for males between highest and lowest LE,
- Eastbourne has the MSOA with the lowest LE (73.4 years for males).

Figure 12: Geographical variation in life expectancy in East Sussex (2016-2020)

Life Expectancy at birth, 2016-2020, Males
East Sussex MSOAs



Life Expectancy at birth, 2016-2020, Females
East Sussex MSOAs

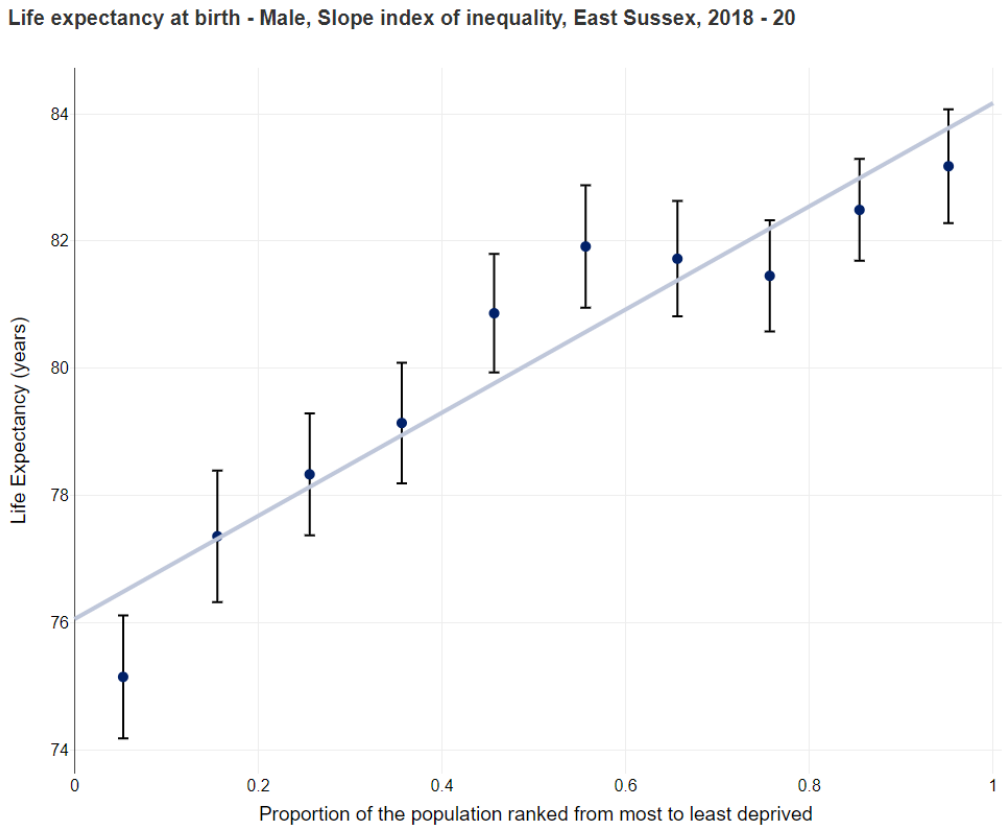


Gap in life expectancy

A Slope Index of Inequality (SII) is a way of measuring how much a health issue, like life expectancy, varies across different levels of deprivation in a population. This shows how big the gap is between the most deprived and least deprived groups, giving a single number to represent this inequality. The steeper the "slope" between these groups, the larger the inequality, meaning a higher SII value. This calculation doesn't just look at the extremes but considers the whole range of deprivation levels within a population to calculate the overall inequality.

Imagine a line on a graph where one axis represents deprivation level and the other represents the health indicator; the SII is essentially the slope of that line. Figure 13 shows an example of the calculation for East Sussex for Life Expectancy, where the SII equals 8.1. This is calculated by subtracting where the line of best fit starts and finishes with reference to the y axis. So 84.1 – 76 = 8.1

Figure 13: An example of how male Inequality in life expectancy (slope index of inequality) is calculated



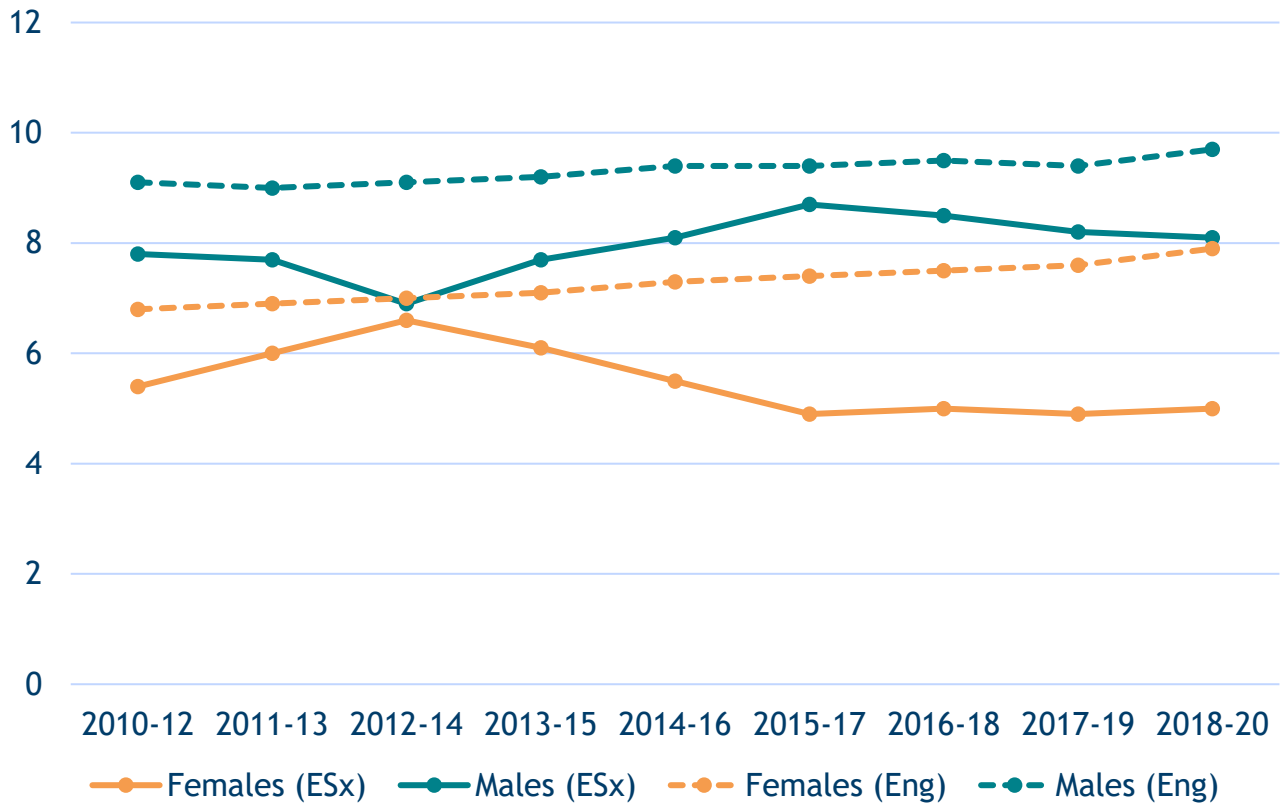
Nationally inequality in LE has been slowly increasing (getting worse) for both males and

females. In East Sussex the trend is not so clear (figure 14).

Inequality in LE for males in East Sussex:

- Has been falling (getting better) for males since 2015-17 but following a period of increased inequality,
- Has been plateauing for females since 2015-17 but following a period of decreasing (improving) inequality,
- is lower (better) in East Sussex compared to England,
- is greater (worse) for males (SII = 8.2 years in 2017-2019) compared to females (SII = 4.9 years in 2017-2019) (figure 14).

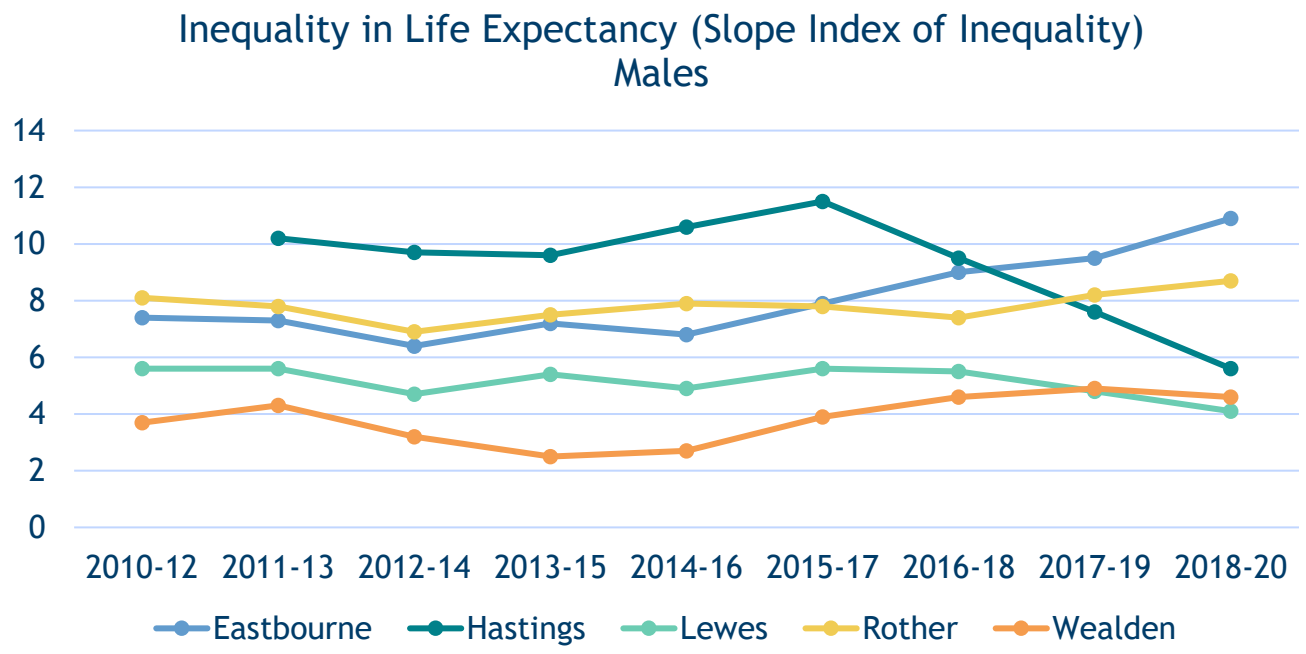
Figure 14: Inequality in life expectancy (slope index of inequality) East Sussex



Due to small-area variation detailed analysis of inequality in LE is not possible other than identifying that:

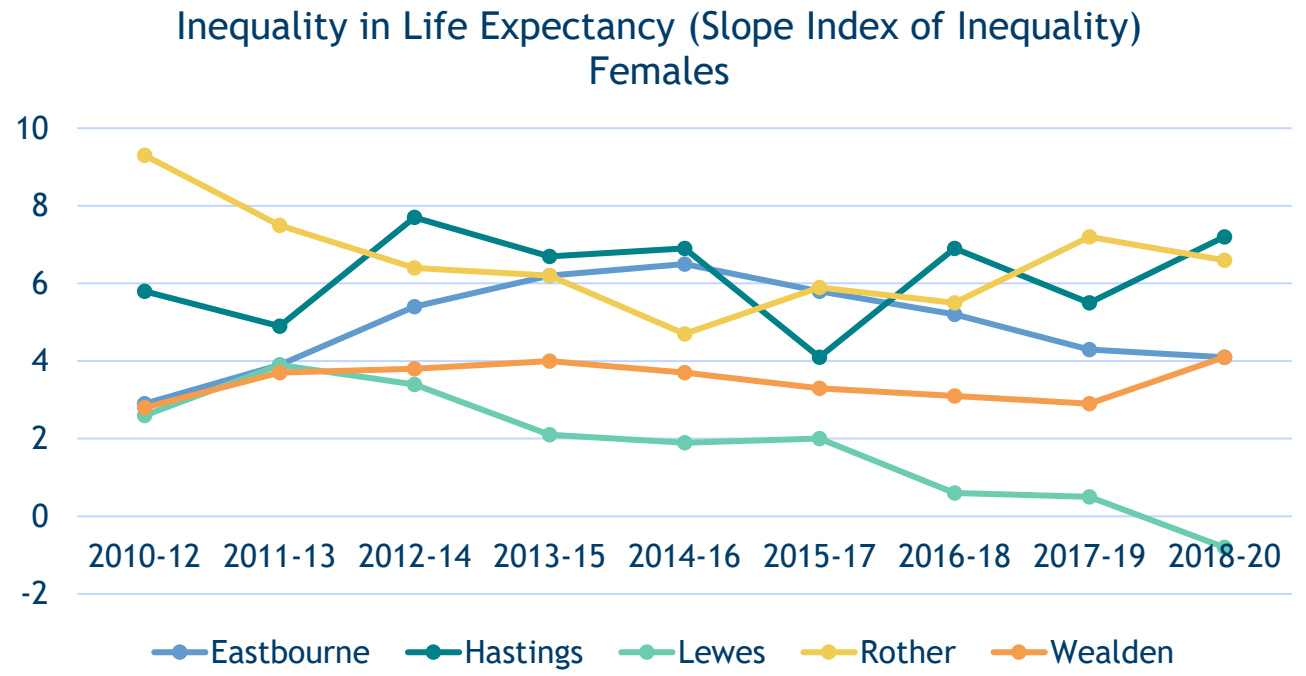
- inequality in LE for males is greatest in Eastbourne (SII = 10.9) (figure 15)

Figure 15: Inequality in Life Expectancy (Slope Index of Inequality), Districts and Boroughs: Males



- inequality for females is greatest in Hastings (SII = 7.2) (figure 16).

Figure 16: Inequality in Life Expectancy (Slope Index of Inequality), Districts and Boroughs: Females

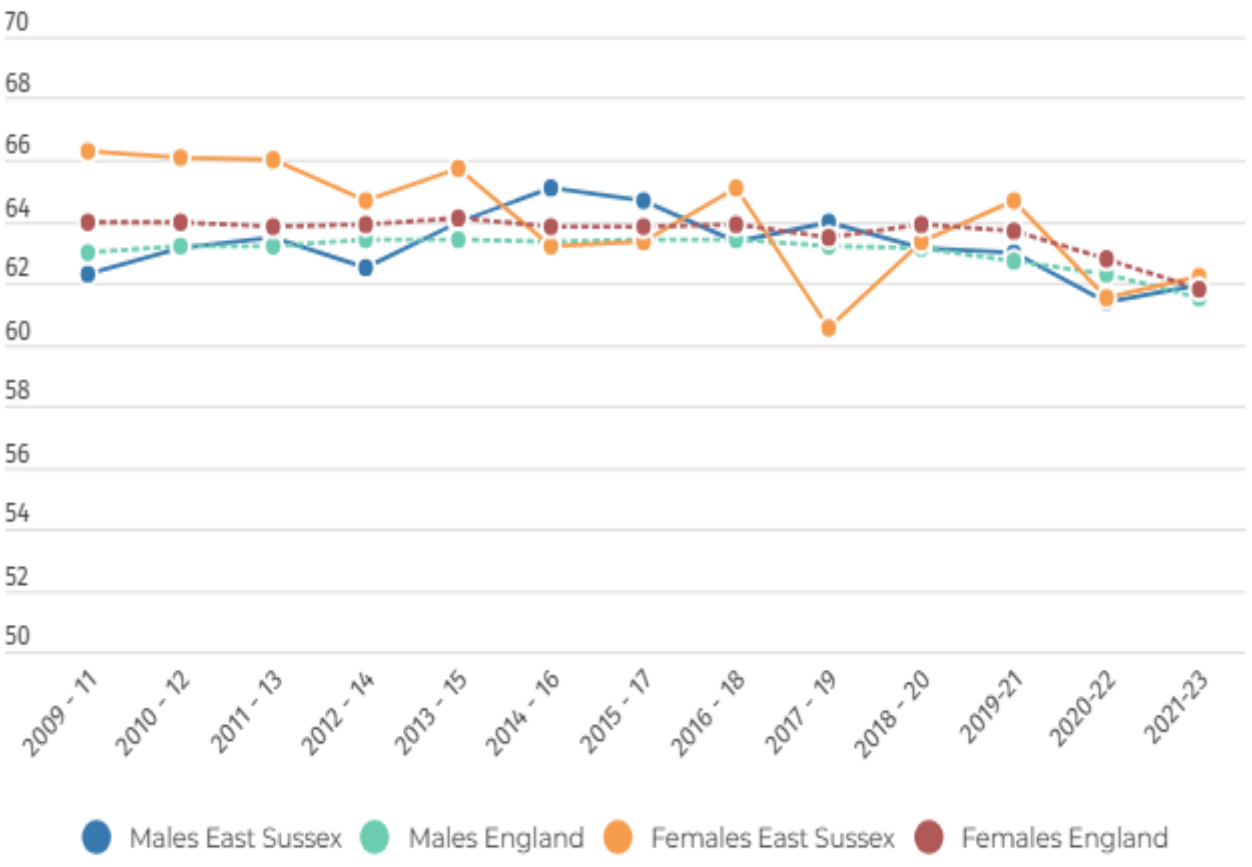


Healthy life expectancy (HLE)

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. The length of their life that people live in good health is decreasing, and those from less affluent areas will have shorter life expectancy and often spend more of that time not in good health than others. In the latest time period (2021-23) in East Sussex, HLE:

- is 61.8 years for males, slightly above England (61.5)
- is 62.2 years for females, slightly above England (61.9)
- Is generally on a downward trajectory for both males and females, similarly to nationally. However, in the last time period has risen slightly, unlike nationally.

Figure 17: Healthy Life Expectancy at birth, East Sussex and England - 2009/11 to 2018/20



NB: note axis starts at 60

Healthy Life Expectancy by deprivation

- On average, people living in the most deprived communities in England have over 18 years less of their lives in good general health than those living in the least deprived areas.
- There is a 14.9 year gap for males, and 13.4 years for females between the most and least deprived quintiles in East Sussex.
- HLE has increased in males across all deprivation quintiles between 2011 and 2021.
- HLE has slightly decreased in females in 3 of the 5 quintiles (including the most and least deprived areas) between 2011 and 2021.
- Also, in 2021 for the first time, healthy life expectancy for those in the least deprived areas is higher in males than females.

Figure 18: Healthy Life Expectancy in East Sussex by deprivation quintile - males 2011 and 2021

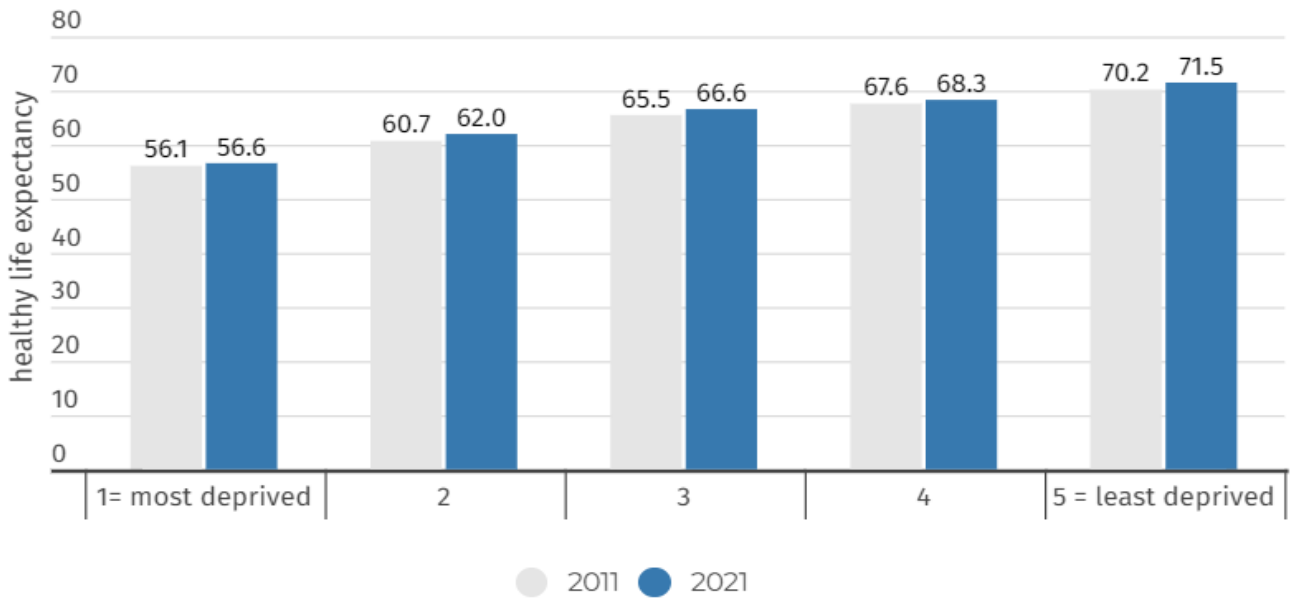
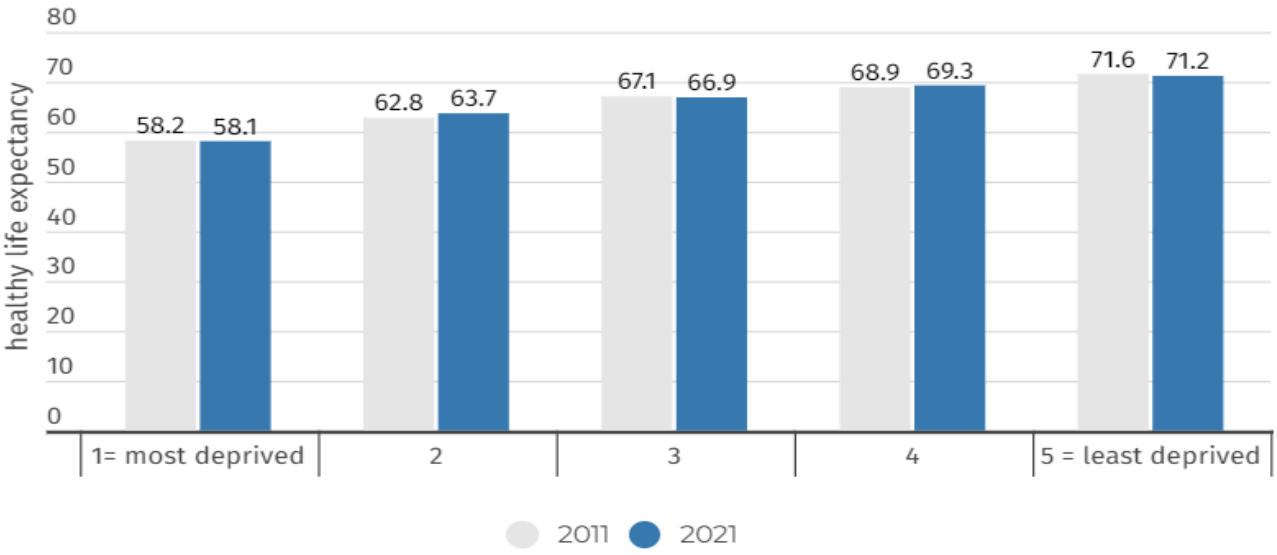


Figure 19: Healthy Life Expectancy in East Sussex by deprivation quintile - females 2011 and 2021



Years people spend with a disability/health issue

The Global Burden of Disease (GBD) is an international tool looking at the prevalence of a condition and the relative harm caused, including an estimation of the years of life lived with any short-term or long-term health loss. Disability-Adjusted Life Years (DALYs) are a measure of the burden of disease, calculated by combining years of life lost due to premature mortality (YLLs) and years lived with disability (YLDs). The Global Burden of Disease uses DALYs to assess the impact of diseases, injuries, and risk factors on global health

According to GBD, in 2021 in East Sussex, COVID-19 accounted for over 2x the DALYs of any other cause. Beyond COVID-19, the specific diseases in East Sussex with the greatest potential impact on DALYs are ischemic heart disease, back pain, Alzheimer's disease and COPD. All the top 10 causes of DALYs are non-communicable diseases, with the exception of COVID-19 and falls. However, while this tells us about the presence or absence of disease or disability, it does not identify if those people who have these conditions would say they are experiencing poor health.

Figure 20: East Sussex top 10 causes of disability-adjusted life years (DALYs), 2021 (number of DALYs per 100,000)

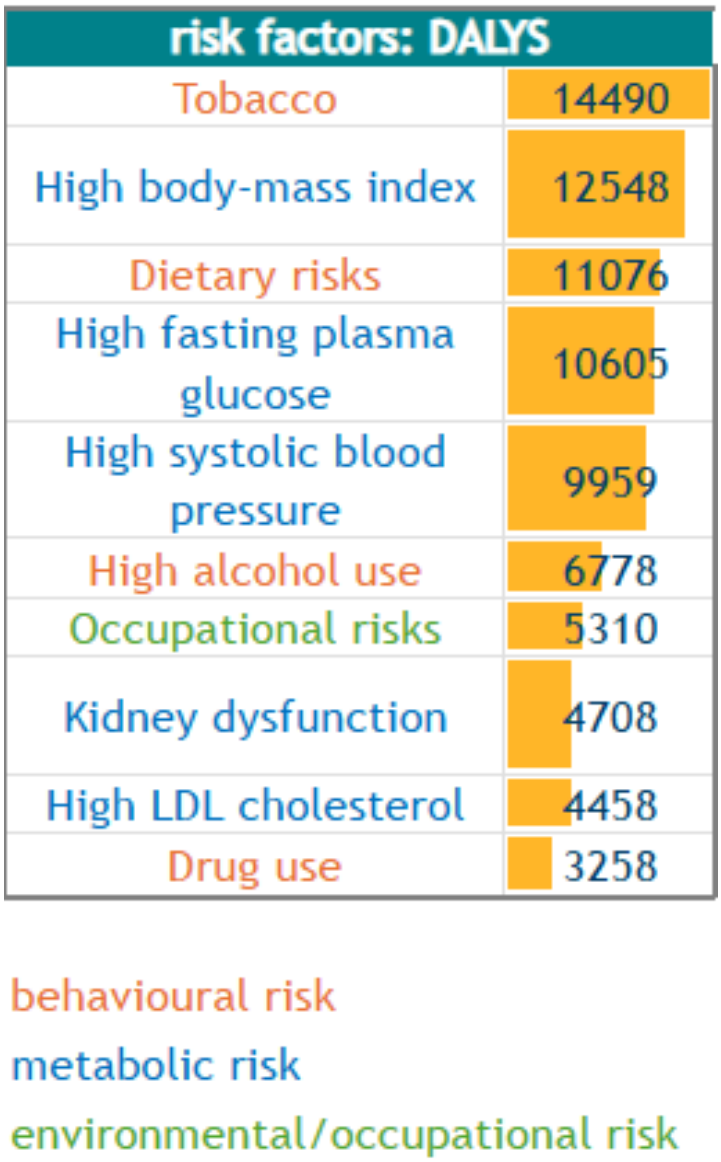
Top 10	East Sussex	
1	COVID-19	3821
2	Ischaemic heart disease	1823
3	Low back pain	1555
4	Alzheimers disease	1242
5	COPD	1234
6	Stroke	1131
7	Lung cancer	1094
8	Depressive disorders	1051
9	Diabetes	932
10	Falls	885

Source: Global Burden of Disease, 2025

A risk factor of ill health or mortality is an attribute, behaviour, exposure or other factor which is causally associated with greater risk of a disease or injury. There are three types of risk: metabolic risks (e.g. high blood pressure); socioeconomic and environmental 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). There are inequalities in the prevalence of these risk factors for health, with higher prevalence in more deprived communities and among particular populations.

Tobacco is the top risk factor for both deaths and disability-adjusted life years (DALYs). Smoking is associated with most indicators of disadvantage, and while prevalence is generally declining nationally, the decrease is slower in more deprived communities, meaning that the gap in prevalence between the most and least deprived has increased.[9]

Figure 21: East Sussex top 10 risk factors for disability-adjusted life years (DALYs), 2021 (numbers of deaths)



Source: Global Burden of Disease, 2025

Mortality

All age, all-cause mortality in East Sussex has significantly increased in 2020-2022 from 2010-2012. This is the case for both males and females and across all deprivation quintiles. This is due to the mortality experienced as a result of the Covid-19 pandemic.

Figure 22: All-age All-cause mortality rate in East Sussex by deprivation (directly standardised rate) , 2010-12 and 2020-22: males

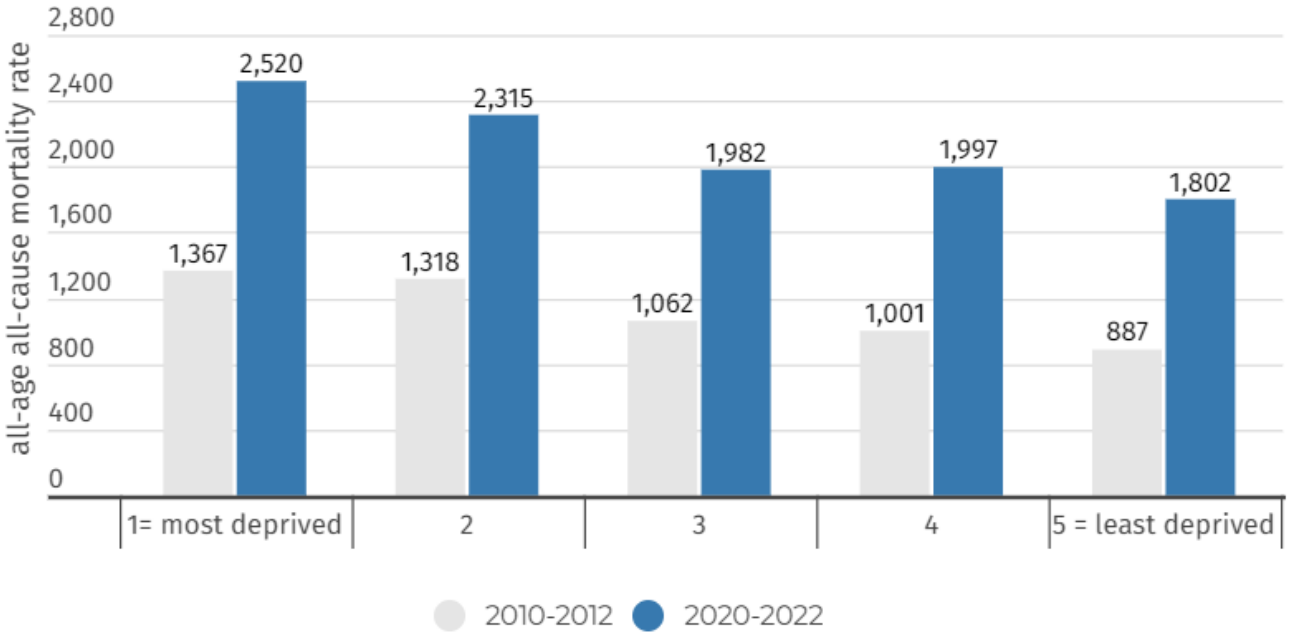
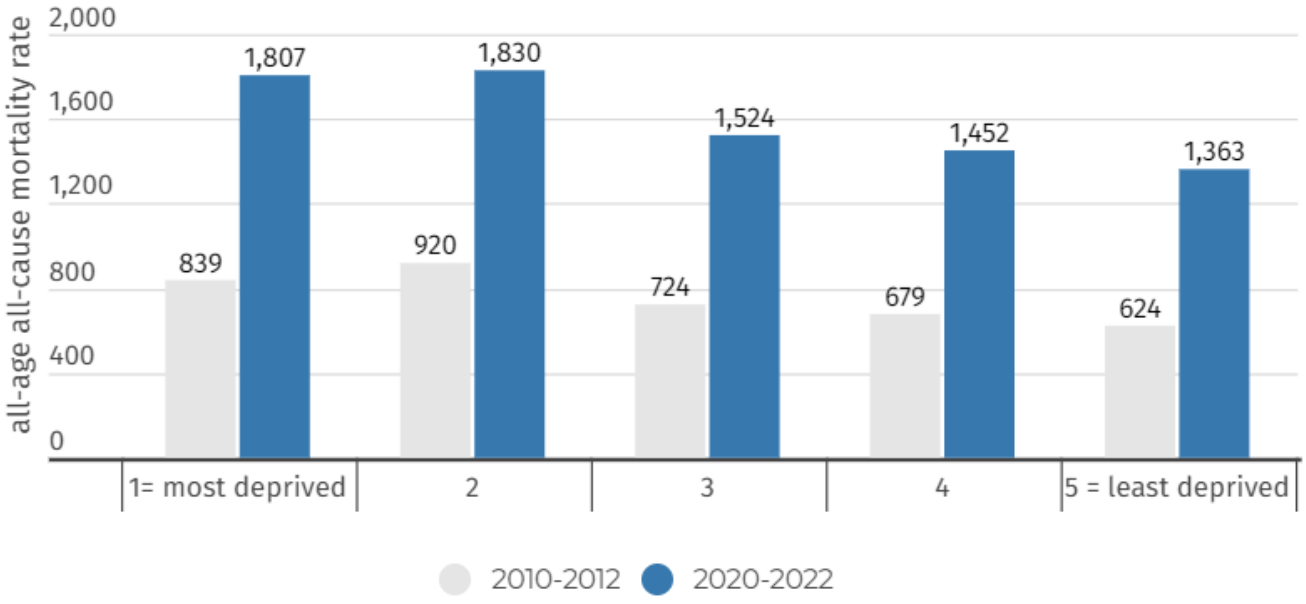


Figure 23: All-age All-cause mortality rate in East Sussex by deprivation (directly standardised rate), 2010-12 and 2020-22: females



Causes of mortality

Good health should be fundamental to all our lives, but inequalities in mortality risk contribute to sustaining lower levels of life expectancy in some groups or populations

compared to others. Premature and preventable mortality is therefore an important measure of health inequality to determine differences in risk of poor health, and in opportunity to live a healthy life. The Department of Health and Social Care (DHSC) Major Conditions Strategy identifies that in most instances, poor health arises from six major health conditions: cancer, heart disease, musculoskeletal disorders, mental ill-health, dementia and respiratory diseases. In East Sussex, for all causes and all ages, the latest data (2023) shows Alzheimer disease and other dementias to be the leading cause of mortality, followed by ischaemic heart disease, chronic lower respiratory diseases and stroke.

Figure 24: East Sussex top 10 causes of mortality, 2023 (numbers of deaths)

Top 10	East Sussex	
1	Alzheimer disease and other dementias	788
2	Ischaemic heart disease	557
3	Chronic lower respiratory diseases	388
4	Stroke	381
5	Heart failure and ill-defined heart disease	359
6	Trachea, bronchus, lung cancers	289
7	Colon and rectum cancers	237
8	Influenza and pneumonia	233
9	Symptoms, signs and ill-defined conditions	208
10	Lymphomas, multiple myeloma	157

Source: Public Health Mortality Files, 2025

The greatest overall mortality risks are metabolic risks (high systolic blood pressure, high fasting plasma glucose, high BMI, high cholesterol and kidney disfunction). These are linked to:

- behavioural risks (tobacco, alcohol and dietary risks), and
- occupation/environmental risks (cold weather, occupational risks, air pollution).

Figure 25: East Sussex top 10 risk factors for deaths 2021 (numbers of deaths)

Top 10	risk factors: deaths	
1	Tobacco	660
2	High systolic blood pressure	640
3	Dietary risks	558
4	High body-mass index	375
5	High fasting plasma glucose	370
6	High LDL cholesterol	269
7	Kidney dysfunction	264
8	Non-optimal temperature	221
9	Occupational risks	200
10	High alcohol use	195

behavioural risk
metabolic risk
environmental/occupational risk

Source: Global Burden of Disease, 2025

Causes of premature mortality

Overall, in 2023 in East Sussex, the leading cause of premature mortality was ischaemic heart disease, accounting for 166 deaths in people aged under 75 years. Cancers of the trachea, bronchus and lung; chronic lower respiratory diseases; and liver disease are the next greatest causes of premature mortality in the county (Figure 24).

Figure 26: East Sussex top 10 causes of premature mortality, 2021 (numbers of deaths)

Top 10	East Sussex	
1	Ischaemic heart disease	166
2	Trachea, bronchus, lung cancers	146
3	Chronic lower respiratory diseases	130
4	Cirrhosis and other diseases of liver	91
5	Colon and rectum cancers	89
6	Breast cancer	69
7	Suicide	63
8	Stroke	59
9	Pancreas cancer	50
10	Lymphomas, multiple myeloma	49

Source: Public Health Mortality Files, 2025

At a District and Borough level in East Sussex in 2023:

- Ischaemic heart disease remained the leading cause of premature mortality in Eastbourne, Lewes and Rother, whereas in Hastings it is Chronic lower respiratory disease and in Wealden Trachea, bronchus and lung cancers are the leading cause. .
- In Eastbourne, Hastings and Rother, Ischaemic heart disease, Chronic lower respiratory disease and Trachea, bronchus and lung cancers are the three leading causes of premature mortality
- In Lewes and Wealden, there are higher premature deaths attributed to colon and rectum cancers than to lower chronic respiratory diseases.
- Unlike the other Districts and Boroughs, in Wealden, suicide is not in the top ten causes of premature death (Figure 25).

Figure 25: Top causes of premature mortality (under 75s) by district and borough, 2021 (number of deaths)

Top 10	Eastbourne		Hastings		Lewes		Rother		Wealden	
1	Ischaemic heart disease	40	Chronic lower respiratory diseases	40	Ischaemic heart disease	30	Ischaemic heart disease	31	Trachea, bronchus, lung cancers	29
2	Trachea, bronchus, lung cancers	27	Ischaemic heart disease	38	Trachea, bronchus, lung cancers	27	Trachea, bronchus, lung cancers	29	Colon and rectum cancers	28
3	Chronic lower respiratory diseases	20	Trachea, bronchus, lung cancers	34	Colon and rectum cancers	18	Chronic lower respiratory diseases	27	Ischaemic heart disease	27
4	Cirrhosis and other diseases of liver	20	Cirrhosis and other liver disease	20	Chronic lower respiratory diseases	17	Breast cancer	23	Chronic lower respiratory diseases	26
5	Colon and rectum cancers	15	Colon and rectum cancers	19	Suicide	16	Cirrhosis and other liver disease	19	Breast cancer	22
6	Accidental poisoning	12	Suicide	15	Cirrhosis and other liver disease	15	Suicide	12	Stroke	18
7	Suicide	12	Stroke	14	Lymphomas, multiple myeloma	14	Stroke	10	Cirrhosis and other liver disease	17
8	Stroke	11	Accidental poisoning	13	Pancreas cancer	12	Colon and rectum cancers	9	Oesophagus cancer	14
9	Pancreas cancer	9	Influenza and pneumonia	12	Breast cancer	10	Pancreas cancer	9	Pancreas cancer	12
10	Brain cancer	8	Lymphomas, multiple myeloma	10	Brain cancer	8	Dementia	9	Lymphomas, multiple myeloma	12

Source: Public Health Mortality Files, 2025

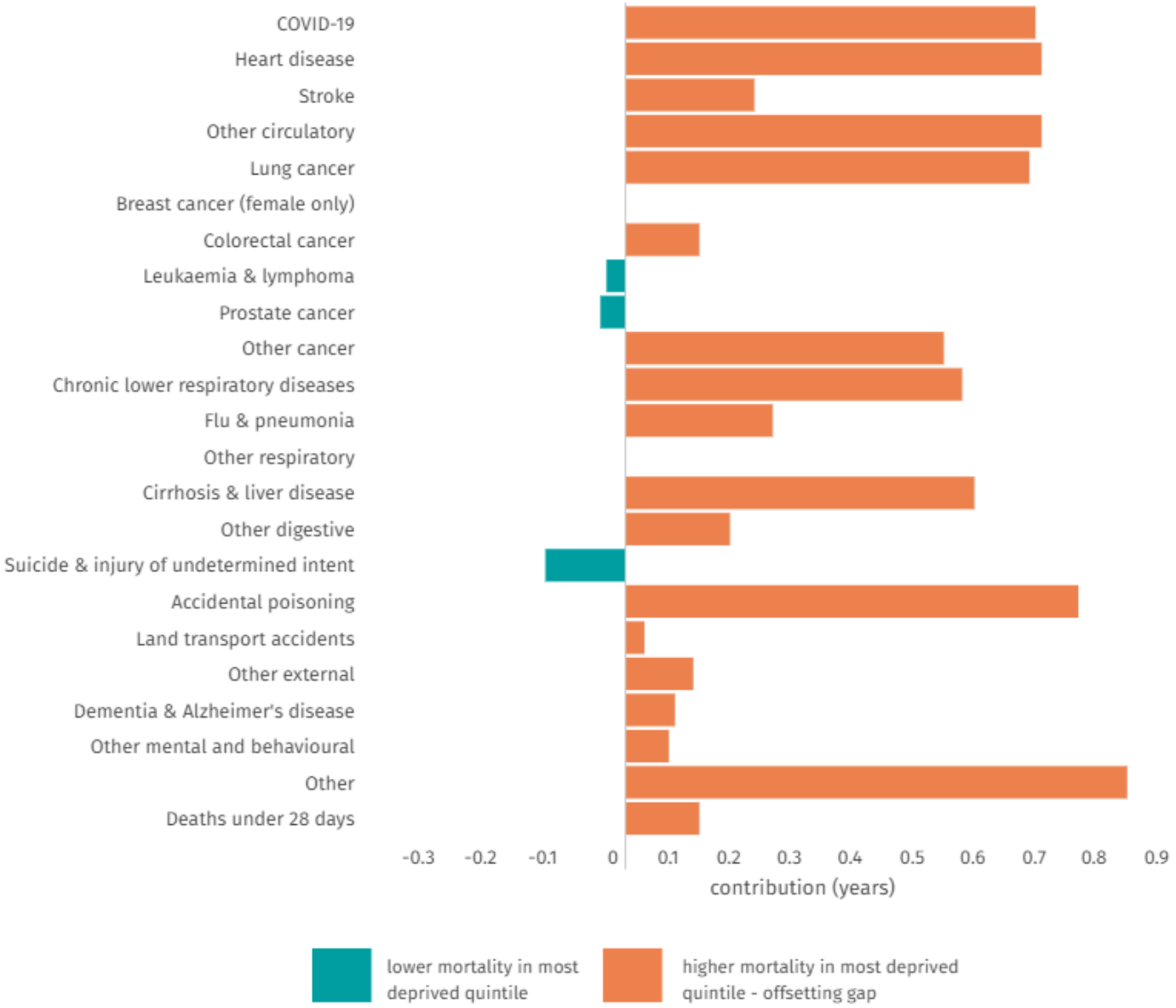
Causes of inequality in premature mortality in East Sussex

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

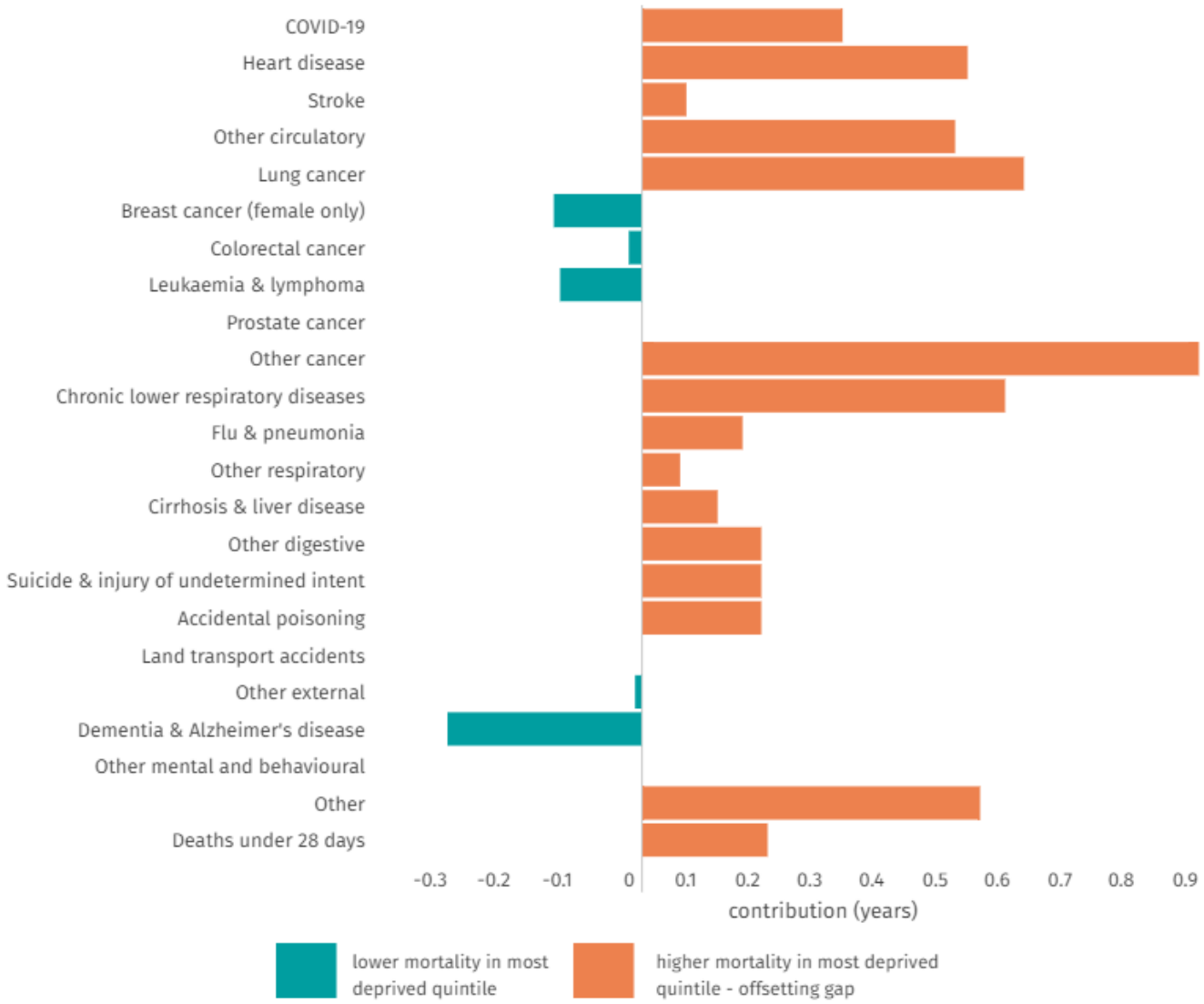
- The biggest contributors to the gap between the most and least deprived areas (the highest mortality difference) for both men and women are:
- circulatory disease (predominately heart disease, other circulatory and a smaller contribution from stroke), and
- cancer (primarily lung cancer).
- Dementia and Alzheimer's, breast cancer, leukaemia and lymphoma, and colorectal cancer are the only causes of death with higher mortality in the least deprived quintile for females.
- Suicide and injury of undetermined intent, prostate cancer and leukaemia and lymphoma are the only causes of death with higher mortality in the least deprived quintile for males.

Figure 27: Number of years reduction in life expectancy at birth in East Sussex due to specific causes, Males, 2020-21



Source: OHID Segment Tool

Figure 28: Number of years reduction in life expectancy at birth in East Sussex due to specific causes, Females, 2020-21



Source: OHID Segment Tool

Geography

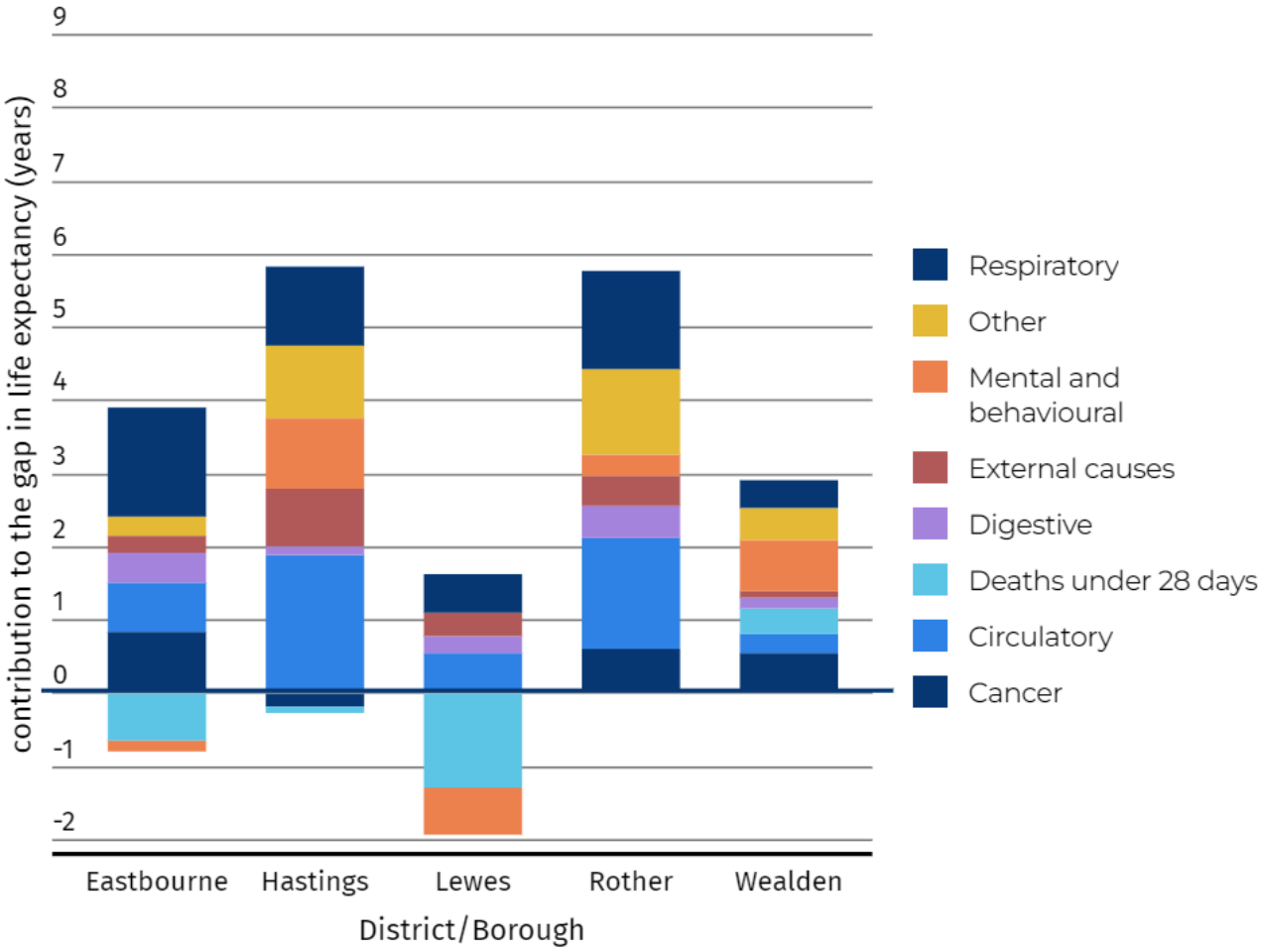
Looking at a lower level geography reveals patterns hidden when looking at the county as a whole. This gives a better indication about where to explore further to think about interventions. Please note, the latest data available for districts and boroughs is 2017-19.

At a District/Borough level, for females:

- Respiratory conditions are the largest contributor to the gap in LE in Hastings and Eastbourne

- Circulatory disease is the largest contributor for all other districts and boroughs.
- External causes also have a larger contribution to the gap for women in Hastings and Eastbourne than in Lewes, Rother and Wealden.

Figure 29: Broad causes of the gap in LE between most and least deprived quintiles within districts and boroughs: Females, 2017-19

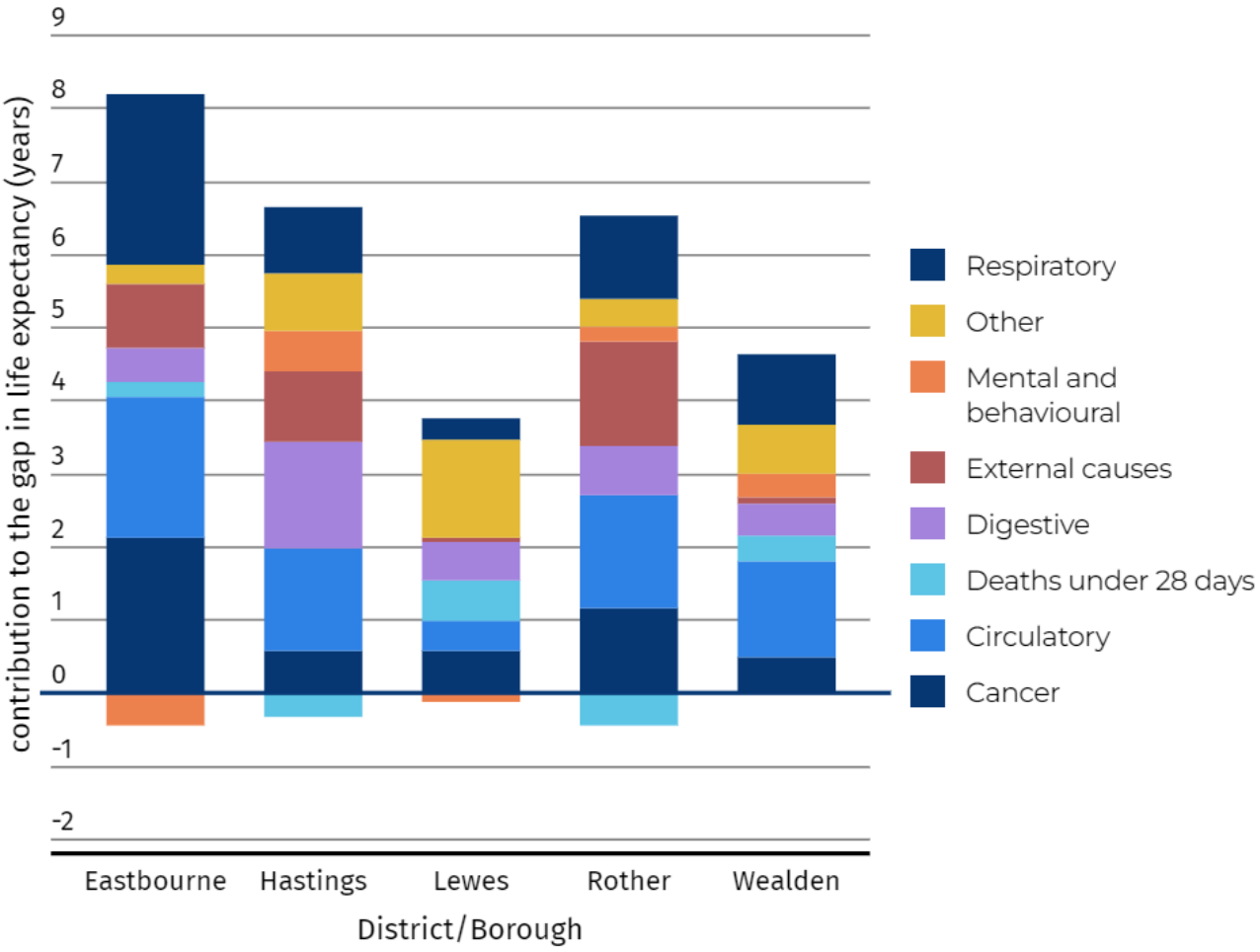


Source: OHID segment tool

At a District/Borough level, for males:

- 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.
- Eastbourne is the only district or borough where cancer is the largest contributor to the gap in life expectancy.

Figure 30: Broad causes of the gap in LE between most and least deprived quintiles within districts and boroughs: Males, 2017-19



Source: OHID segment tool

Many of these risk factors are largely modifiable in that interventions aimed at them as well as early identification and management and treatment of conditions, can significantly reduce disease prevalence and thus the gap in life expectancy. 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.

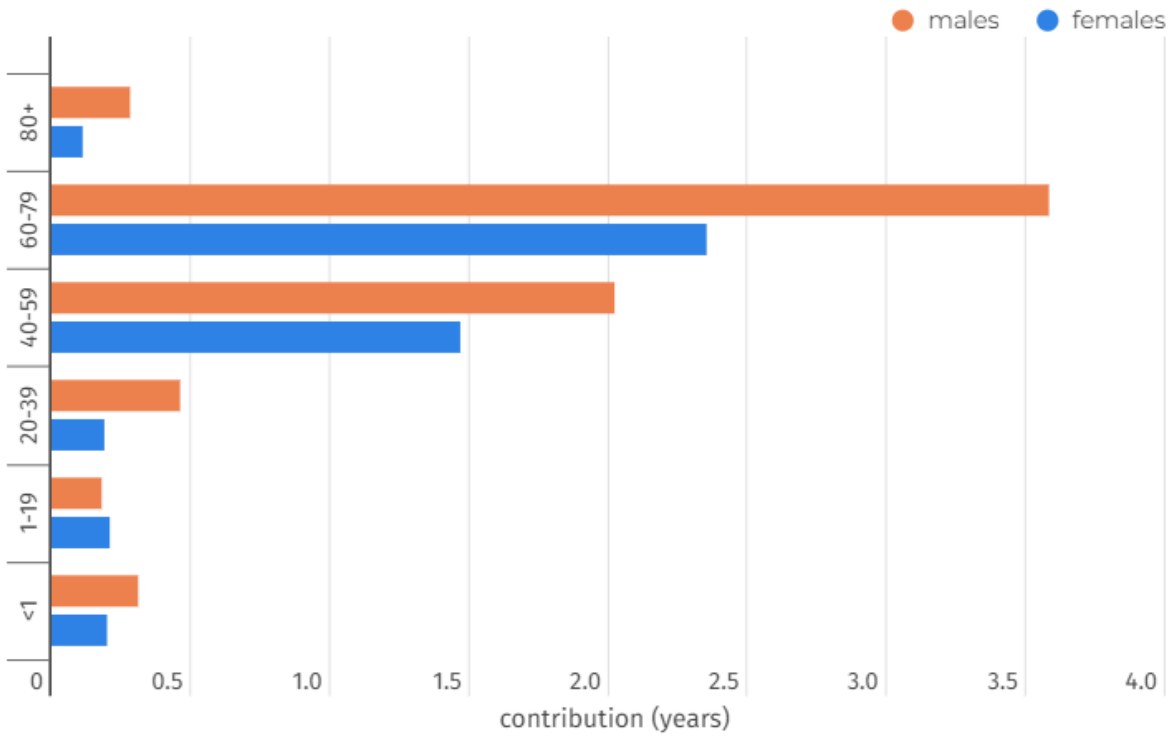
Age

Between the most and least deprived areas in East Sussex:

- 60-79 year olds have the greatest gap in life expectancy for both men and women.

- males between the age of 20-80 years have a greater contribution to the gap in life expectancy between the most and least deprived than for females.
- health inequalities and accumulation of risk have a greater impact on mortality for females aged 1-19 in the most deprived compared to least deprived areas than for males aged 1-19 (figure 29).

Figure 31: Gap in LE between most and least deprived quintiles by broad age group, 20-21



Source: PHE segment tool

Ethnicity

The NHS Race and Health Observatory identified that the Covid 19 pandemic has demonstrated that the limited availability of ethnicity data and the quality of the data are reducing understanding of ethnic inequalities, and the ability to identify effective responses.[10] Even understanding patterns of mortality can be difficult as there is no available data on mortality rates by Ethnic Group as a county level. However, OHID analysis at a national and region level (Table 2) shows that, in the South East compared to England:

- People of Black Ethnicity have fewer than expected deaths while in England they have

the second highest excess deaths of any ethnic group

- Those identifying as Other ethnic group had significantly higher excess deaths
- People of Mixed Ethnicity had slightly lower excess deaths than seen nationally.

Figure 32: Excess mortality in England and the South East by Ethnic Group, Jan-Dec 2023

Ethnic Group	Registered deaths	Expected deaths	COVID-19 deaths	Excess deaths	Ratio: registered/ expected South East	Ratio: registered/ expected England
All	78,851	75,756	2,302	3,095	1.04	1.05
Asian	1,576	1,570	46	6	1.00	1.03
Black	500	561	15	-61	0.89	1.10
Mixed	310	287	4	23	1.08	1.18
Other	271	200	14	71	1.36	1.07
White	76,183	73,143	2,223	3,040	1.04	1.05

Source: OHID

NB: This is the ratio between deaths in each specific ethnic group registered between January and December 2023 and the estimate of expected deaths for the same 12 months in the preceding 5 years.

Section 3: What should we be doing:

> "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." [11]

Addressing health inequalities has often focused on actions by the health and care system, the NHS and the Department of Health and Social Care[12]. However, this focus misses the wider determinants of health such as education and employment, housing, social networks, the places, the environments in which we live, and the extent to which these encourage exercise, a healthy diet, and important social connections.

Actions to reduce health inequalities need to go beyond the provision and delivery of healthcare services and requires a joined-up, multi-agency and co-produced place-based approach across the whole of society, and across all the social determinants of health.[11] This section outlines some of the key guidance, policies and best practice for reducing health inequalities in the UK.

The 2010 Marmot review - sets out 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. The report creates 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 six recommendations consider different stages of life, healthy standards of living, communities and places and ill health prevention:

- 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 2020 Health Equity in England: The Marmot Review 10 Years On report, 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 policy implementation.

- Early intervention to prevent health inequalities.
- Develop the social determinants of health workforce.
- Engage the public.
- Develop whole systems monitoring and strengthening of accountability for health inequalities.

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 emphasises 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.

Government guidance states that to have real impact at population level, interventions to address health inequalities need to be evidenced based, with outcomes orientated, well resourced, sustainable and systematically delivered at a scale to reach large sections of the population.[13] Actions should be universal (at population level), but with a scale or intensity that is proportionate to the level of disadvantage. This *proportionate universalism* would ensure a greater intensity of action is targeted at those who most need it, through:

- **Understanding and intervening appropriately at different levels of risk** - People experience different yet interconnecting levels of risk of poor health, with one risk often leading to another.
- **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 longer term to a reduction in long-term conditions.
- **Intervening across the life course** – Action needs to be taken to reduce the accumulation of health inequalities from before birth through to old age. Some actions need to be focussed on specific stages of the life course (those affecting early years, work and employment). Other actions (skills development) will impact on several stages of the life course, and some (community, standard of living) will impact at all stages.

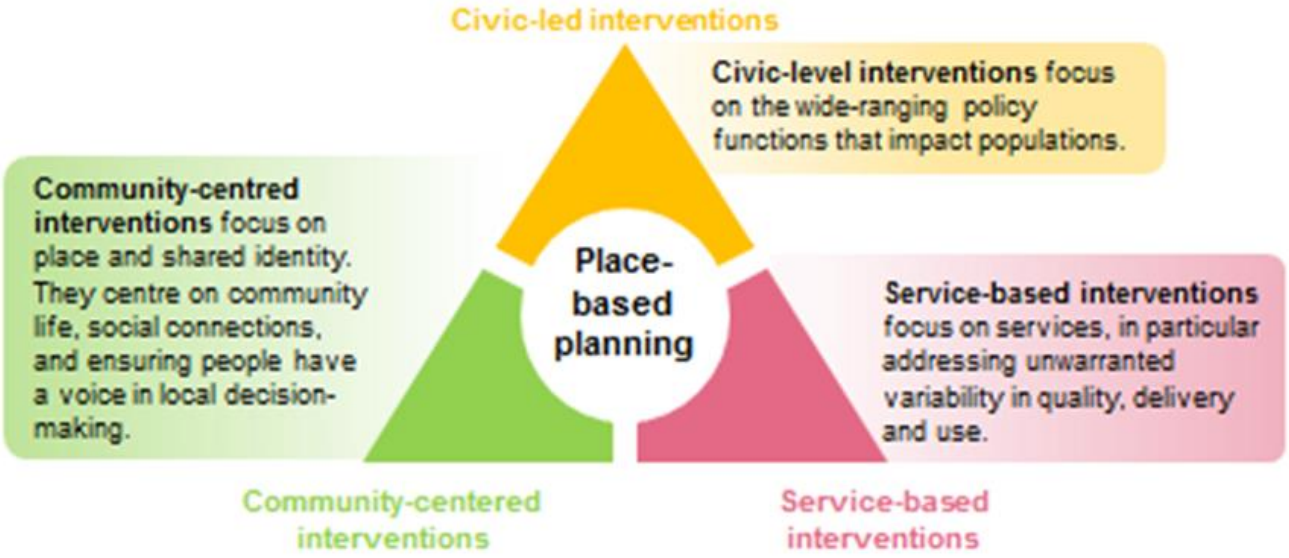
Effective whole system strategies require system leadership and planning from a range of civic and community partners. They will need to understand and take relevant action of multi-component inventions: rooted in the place they will be delivered, that address individuals, communities, the living and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

The 2024 Child Health Equity Framework was developed by the Institute of Health Equity, Barnardo's and three Integrated Care Systems (ICSs) with input from over 300 children, and sets out the social determinants of health for children and young people in order to underpin action for achieving greater health equity. The Framework illustrates where Integrated Care Systems (ICSs) can take action to improve health for children and young people and reduce inequalities in a time when more families are living in poverty, health is deteriorating, and inequalities are widening. To achieve this, joined-up action to improve health through the social determinants is vital. The framework includes five different domains: socioeconomic political systems; social position; living conditions; interaction with services, and; health and wellbeing outcomes, and identifies core indicators for monitoring child health equity.

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** (e.g. workplace health and smoking cessation) use person centered approaches, 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 community assets e.g. skills, knowledge, social networks and community organisations.
3. **Civic level action and interventions** (healthy public policy, e.g. 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. These have the greatest reach of any intervention, with local authorities a key driving force behind place-based action to reduce inequalities

Figure 33: Population Intervention Triangle (PIT) model for planning action to reduce health inequalities



Source: Public Health England, 2021

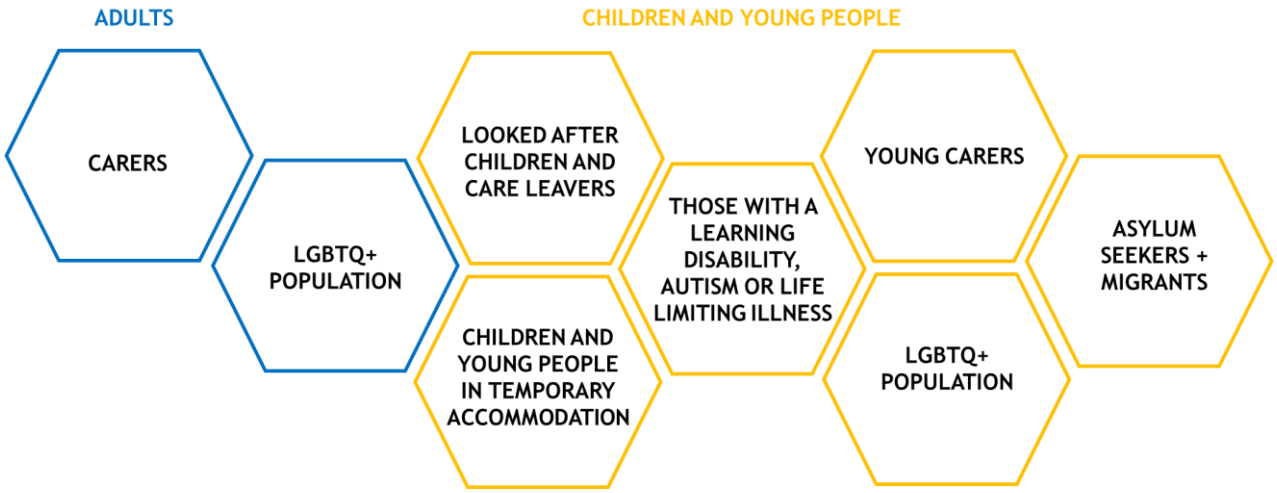
Interventions at these levels can separately impact on population health, but joint working across the interfaces between the civic, service and community sectors would have a much greater impact.

National Initiatives to tackle Health Inequalities:

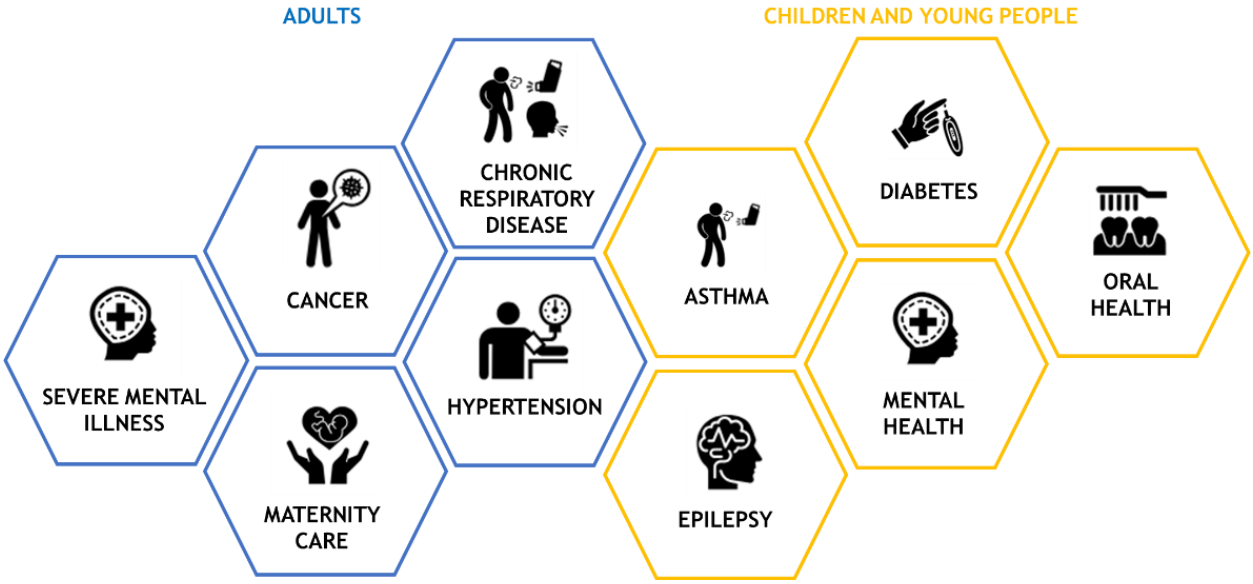
The NHS launched the Core20PLUS5 approach to reducing health inequalities to support the reduction of health inequalities at both national and system level. The approach defines a target population cohort – the 'Core20PLUS' – and identifies '5' focus clinical areas requiring accelerated improvement.

- The **'Core20'** is the most deprived 20% of the national population as identified by the national Index of Multiple Deprivation (IMD).
- The **'PLUS'** is the Integrated Care System (ICS)-determined population (inclusion health) 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.

In East Sussex, the PLUS groups ARE:



- The **'five'** clinical areas of focus for adults and children and young people in East Sussex are:



In 2023, NHS England published its first health inequalities statement setting out the powers available to relevant NHS bodies to collect, analyse and publish information and suggestions on how those powers should be exercised in connection with this information. This is supported by guidance for NHS commissioners to meet their legal duties in respect of equality and health outcomes.

Many of the actions and principals of reducing health inequalities align with the Governments 'Levelling up' agenda for central and local government and other agencies with a stake in improving health. Health is a key part of this agenda which 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 service initiatives** – tend to be 'upstream interventions' targeting structural factors and not requiring much individual agency.
- **Long-term, multi-sector, multi-component action** – cross-government and cross-sector action to address the unequal distribution of wider determinants of health.
- **Locally designed focus** – Services and programmes designed around specific needs of places and communities, especially in disadvantaged or ethnically diverse areas.
- **Targeting disadvantaged communities** –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.

The Government's subsequent 2022 Levelling Up White Paper, identifies 12 "national missions" to tackle regional inequality and sets up a system for measuring progress.

Section 4: How are we tackling health inequalities in East Sussex

The 2010 Marmot review (see section on 'What Should We Be Doing') recommended that actions to reduce inequalities in health should consider different life stages, standards of living, communities and places and ill health prevention.

Given this breadth of scope, much of the activity of ESCC public health, other council departments, NHS organisations, and VCSE sector organisations can contribute to reducing health inequalities and reducing health inequalities should be embedded within everything we do.

In addition to this, there are specific strategies and work programmes for reducing health inequalities in East Sussex and across Sussex. This section highlights some of the key drivers for reducing health inequalities rather than a comprehensive list of all work towards that goal.

Pan-Sussex and national strategies for reducing health inequalities

Sussex Integrated Care Strategy and Delivery Plan

The Sussex Health and Care Integrated Care System (ICS) developed its strategy 'Improving Lives Together' in 2022. This highlights the importance of health inequalities in Sussex, particularly noting deprivation in coastal communities. To deliver on the strategy, a shared delivery plan was created. This plan sets out how the ambitions in the strategy will be delivered over five years from 2023/24. The plan contains a number of actions to specifically reduce health inequalities in the first year and beyond, including:

- developing a children and young person Core20PLUS5 work programme;
- improving identification and treatment of people with hypertension and raised cholesterol (risk factors for cardiovascular disease), and tracking achievement towards this goal for different groups of the population, to reduce inequalities;
- supporting people to quit smoking who are receiving inpatient, maternity and mental health services;
- reducing inequalities in waiting times and cancellation rates among people living in the deprived areas or with protected characteristics.
- Establishing an inclusion health programme
- Improving data recording of ethnicity across all providers
- Improving data recording for people who are LGBTQ+ or with a learning disability

The plan also outlines actions to improve the health of people with mental health needs, autism or learning disabilities.

A report outlining progress against the first year of the SDP including on health inequalities shows that there has been an increase in the number of people identified as having hypertension and those who have started treatment; a new, specific approach to tobacco dependency treatment in maternity wards and inpatient wards has been implemented; and a Sussex Inclusion Health Network has been established with a directory of 144 services.

Women's Health Strategy

In 2022 a women's health strategy for England was published and in response, NHS Sussex led a partnership approach to develop a women's health needs assessment and a model of women's health hubs. The needs assessment made a number of recommendations, including several specifically related to reducing health inequalities. The Sussex women's health hubs will provide a number of services to improve women's health. Two hubs, both located in East Sussex, have been operational since July 2024, with additional services for women available from December 2024.

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 was refreshed in 2022/23. This outlines a number of key strategic priorities supported by key actions including ensuring a focus on prevention and recognising the social determinants of health. The plan also describes inequalities in mental health needs in children and young people and outlines the approach to reducing health inequalities. This includes producing equality health impact assessments to ensure that services are appropriate and accessible for the diverse communities using them, for example, locating the mental health support teams in schools in areas of highest need.

Tackling neighbourhood health inequalities direct enhanced service (DES)?

Primary care networks (PCNs) have been contracted with tackling neighbourhood health inequalities since 2021/22. Since October 2021, PCNs have been 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 use a data driven approach to target care and improve outcomes in populations groups where there is greatest opportunity. They should seek to achieve this by working in partnership with their local community organisations to deliver effective outreach

Health Inequalities Programme

In 2023/24 a number of projects were delivered across Sussex to address specific health inequality challenges. Funded by NHS Sussex and delivered with partners across the county, the projects addressed a number of inequalities issues and groups. Twenty Five projects were Sussex-wide and a further 6 were specific to East Sussex (see section below for details).

Key strategies and programmes for reducing health inequalities in East Sussex

East Sussex health and care partnership

The East Sussex Health and Care Partnership brings together NHS, Local Government and Voluntary, Community and Social Enterprise (VCSE) partner organisations to work collaboratively to deliver shared priorities in the Joint East Sussex Health and Wellbeing Strategy and the Sussex Assembly Improving Lives Together Strategy. On behalf of the Health and Wellbeing Board, the Partnership leads on delivering shared programmes aimed at improving population health outcomes and reducing health inequalities. Priorities cover children and young people, mental health, community services and health outcomes improvement for people of all ages and align with pan Sussex SDP plans to ensure a strong focus on the population.

In 2023-24 achievements include:

- The proposition phase of the Hastings Universal Healthcare community frontrunner was delivered, evaluated and next steps identified.
- The initial Hastings Integrated Community Team development sessions were held
- A whole-system action plan was agreed which focuses on the conditions that significantly contribute to gaps in life expectancy and healthy life expectancy (CVD; frailty and healthy ageing; chronic respiratory disease; and mental health). The delivery of this plan has also now begun.
- 11 Family Hubs were opened in East Sussex to provide additional support to families with young children
- A mental health and emotional wellbeing strategic plan to improve wellbeing and

promote whole school approaches in educational settings was developed.

Health Inequalities Programme – East Sussex

In 2023/24 a number of projects were delivered across Sussex to address specific health inequality challenges. Six of these were implemented in East Sussex. Funded by NHS Sussex and delivered with partners, the projects addressed a number of inequalities issues as summarised below.

Supporting carers with complex needs	• **The three practices in Hastings Primary Care Network successfully completed the Carers Quality Markers for primary care.** • **197 carers in crisis were supported across the year** • **Monthly carers support groups and carers clinics set up in Newhaven and Peacehaven, which have been very well attended throughout the year** • **Home visits, in person/ telephone discussions, GP practice/neutral setting visits have all been offered to carers, based on their individual situation.** • **Working relationships between health and adult social care professionals have been strengthened.**
Supporting people misusing alcohol	• An alcohol care team has been established at the Conquest Hospital in Hastings. • As of August 2024 (5 months of delivery) 138 patients have received a service and 283 bed days have been saved. Over 70 referrals have been made to community based alcohol support services. Over 60 staff have received training. • As the service progresses, an evaluation will be carried out to demonstrate impact
Supporting people living in deprived	• Over 100 community members and professionals in Hastings and St. Leonards worked together to co-create,

areas of Hastings to co-create services to improve access to healthcare services	test, refine and evaluate nine potential solutions to unequal healthcare service provision, using a data-informed understanding of the challenges and issues faced by the healthcare system and people accessing it. • Over 70 members of the community from a wide range of social and ethnic backgrounds, including individuals who had not engaged in work like this before, took part in the workshops. • 65% of community members attending the workshops were from wards in the most deprived 20% of LSOAs • The business cases developed by the prototype groups formed the basis of a successful proposal to fund further testing phase. • 120 community members and professionals came together to reflect on and celebrate the achievements made during the prototyping phase. Stalls were also set up by local groups to promote their work during the event. • Prototype initiatives that were cocreated, tested, refined and evaluated are now being used to inform the development of Integrated Community Teams in East Sussex and beyond.
Supporting general practices to better meet the health needs of LGBTQ+ groups	• Over 270 staff attended training on providing services in a more inclusive way for LGBTQ+ populations. 70% of attendees indicated they would make at least one change to their practice after training to make it more inclusive. • 97% of those who had attended training rated the session 4 or 5 stars out of 5. • 81% of attendees would proactively recommend the Inclusion training program
Social prescribing for children and young	• 87 children and young people from 4 primary schools were referred to the social prescribing project to help improve

people	their mental health and wellbeing • 92% of parent survey respondents agreed that the wellbeing of their children and their whole family has improved since the start of the project. • 75% of parent survey respondents agreed that their wellbeing has improved since the start of the project. • 83% of respondents to the children's survey agreed their wellbeing had improved since the start of the project. • 75% of schools felts that there was a reduced demand for this internal MHWB services • We engaged with 25 activity providers (for in person activities) • Vouchers, passes, and other item were provided in place of /alongside activities from 10 different providers: this includes annual passes, vouchers for accessing activities and items such as anxiety packs • Click here to see a short film about the project

East Sussex County Council Adult Social Care and Health Equality and Inclusion Strategy

Building on the achievements of the previous strategy, ESCC is developing its 2024-2027 equality and inclusion strategy. This describes the Adult Social Care and Health department intentions to:

- Deliver leadership on equality and demonstrating commitment
- Engage effectively with residents to make improvements
- Deliver quality services that reflect the diverse needs of local people
- Build a diverse workforce with equality confidence, knowledge and skills

The strategy includes plans to improve engagement and outcomes for people with a range of protected characteristics.

East Sussex Housing Strategy

An East Sussex place-based housing strategy is being developed for publication in 2025. This strategy will take a holistic, horizon scanning approach across the whole sector, including housing development and enablement, housing management and standards, and homelessness prevention. The aim of the strategy is to complement the individual strategies in each district and borough, set a medium- and long-term vision for the development of the sector locally and provide a framework for cross-sector working. The evidence base for the strategy draws on the earlier findings of the report by the Director of Public Health on the links between housing and health. The partnership has also been strengthening its links to governance structures within health and care to ensure this approach is embedded in wider programmes to reduce health inequalities. This includes a new Multiple Compound Needs Board which is overseeing service design for people experience a combination of homeless, poor mental health, substance dependency, domestic abuse and contact with the criminal justice system.

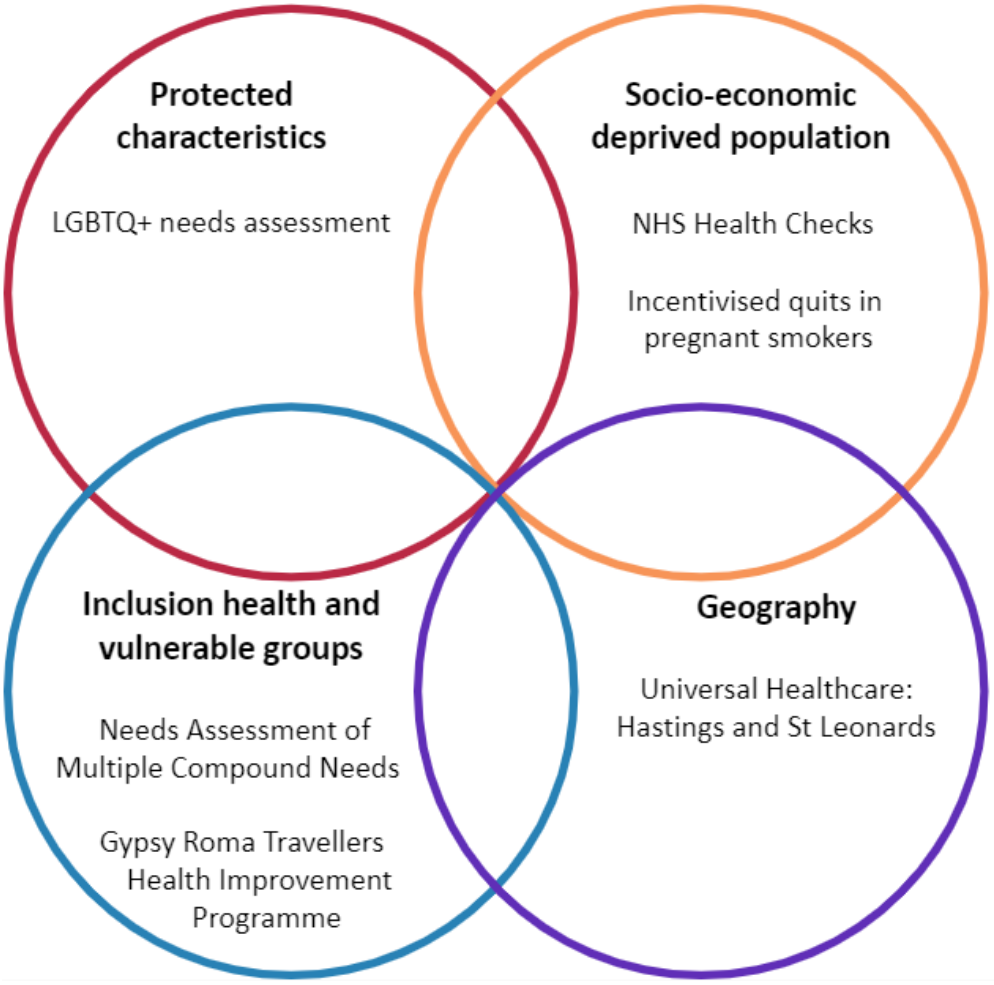
East Sussex Economic Prosperity Strategy

Published in September 2024, East Sussex Prosperity Strategy seeks to secure sustainable economic growth, setting out how – over the next generation – East Sussex can secure better opportunities and living standards for the people who live in the county, and can help businesses to thrive and grow. Jointly produced by the County Council and Team East Sussex, the county's business-led strategic advisory economic growth board, it is an evidence-based strategy with a long-term view to 2050, which will remain fluid to reflect any national and local changes.

Two principles underpin the strategy: the need to achieve net zero and a commitment to embrace the principles of the circular economy across all activities. These will be achieved through actions focused on prosperity for business (flourishing micro-businesses, firms scaling-up, effectively adapting to climate change challenges, and remaining attractive to investment); prosperity for people (better career opportunities for young people, attracting a skilled and diverse workforce, and enabling new skills and career path development over people's lifetimes). An affordable mix of housing will be critical to achieve this. And finally, prosperity for places (ensuring all places in East Sussex thrive and reach their potential, and that creative, cultural and environmental assets are protected and enhanced).

Examples of specific public health work programmes

Whilst all public health work programmes seek to reduce inequalities in health, and there are too many to list, a number of examples are given here to illustrate just a few of the activities led by the public health team to reduce health inequalities.



Protected characteristics

Lesbian, gay, bisexual, transgender, queer (plus all other sexual orientation and gender identities) (LGBTQ+) needs. In 2021, the first East Sussex LGBTQ+ health needs assessment was published, with steering group representation from council departments, NHS organisations, the voluntary sector, and community representatives. The report brings together data from local health and care services, the police, and findings from focus groups and a community survey of more than 400 people. It highlights that while LGBTQ+ people have many of the same health and care needs as their heterosexual and cisgender peers, they also face several health inequalities. For example: high levels of LGBTQ+

discrimination in educational and workplace settings; higher rates of mental health conditions; and concerns about care needs and fears about discrimination in later life. Since publication:

- **LGBTQ+ populations were identified as 'plus group' for East Sussex**. This led to the allocation of NHS Sussex Health Inequalities Programme funding for the LGBTQ+ Inclusion Award aimed at improving data recording of protected characteristics in ESCC, Sussex Community NHS Foundation Trust and East Sussex Healthcare NHS Trust. This was delivered by Switchboard and the Ensuring Everyone Counts project.
- The LGBTQ+ mental health charity **MindOut were funded to deliver** East Sussex Community Peer Support Groups for LGBTQ people; available in Eastbourne.
- **East Sussex County Council also supported the** 'Creating inclusive residential care for LGBTQ+ elders (CIRCLE)' **research project**, funded by the National Institute for Health and Care Research's Applied Research Collaboration Kent, Surrey and Sussex. The research aims to understand how providers of residential care for older people can improve their LGBTQ+ inclusive care offer by supporting and evaluating the impact of LGBTQ+ inclusion in three ways:
- implementing and evaluating the Pride in Care programme in five care homes across Sussex - assessing different elements of LGBTQ+ inclusion (staff attitudes, organisation policies, and communication and marketing materials) and provided recommendations for improvements.
- Organising and evaluating the impact of quarterly online Community of Practice meetings open to anyone working in adult social care who wants to learn more about LGBTQ+ inclusion in residential care.
- Co-designing a free resource for care homes with a group of older LGBTQ+ people and care home managers to make care home environments more LGBTQ+ inclusive.

Socio-economic deprived population

The **NHS health checks programme** aims to identify patients at risk of developing cardiovascular diseases (CVD), chronic kidney disease (CKD), and diabetes. Given that some groups of the population are at greater risk of these conditions, or face greater barriers to attending health checks, the programme in East Sussex particularly targets key groups to encourage their attendance in order to reduce inequalities. These target groups are people

living in areas of greatest deprivation, people with a BMI >30, current smokers, people from ethnic minorities, and people aged 50 and over who have not had an NHS Health Check in the last 10 years.

Incentivised quits in pregnant smokers - East Sussex County Council has partnered with the maternal smoking cessation service at East Sussex Healthcare NHS Foundation Trust to offer financial incentives for targeted groups of pregnant smokers to support them to quit. Eligible service users are offered vouchers, scheduled throughout the duration of their pregnancy, to encourage them to give up smoking. Provision of financial incentives is based on biochemically verified quits, and the financial incentive element of the programme complements the service's universal twelve-week smoking cessation offer. The design of the incentives programme is in line with NICE Guideline [NG209]. This initiative is an example of a universal service being adapted to support a targeted subgroup to achieve better outcomes. Local intelligence shows that rates of smoking in pregnancy in East Sussex have been highest among young people and those living in deprived areas; this information has been used to determine eligibility criteria for the financial incentives programme.

Inclusion health and vulnerable groups

Multiple Compound Needs (also described as multiple complex needs or severe and multiple disadvantage) describes the experience of having several support needs linked to social exclusion, and the multiplying effects of these needs in combination. A person with multiple compound needs is defined as having 3 or more of the following five needs: homelessness, substance or alcohol misuse, mental ill health, domestic abuse and involvement with the criminal justice system. This definition considers both survivors and perpetrators as having that need. The East Sussex public health team is conducting a needs assessment to understand how many residents have multiple compound needs and which population groups are most affected, and to systematically assess the health needs of this population within East Sussex. The needs assessment will be used to guide the development of future support offers for this group of people.

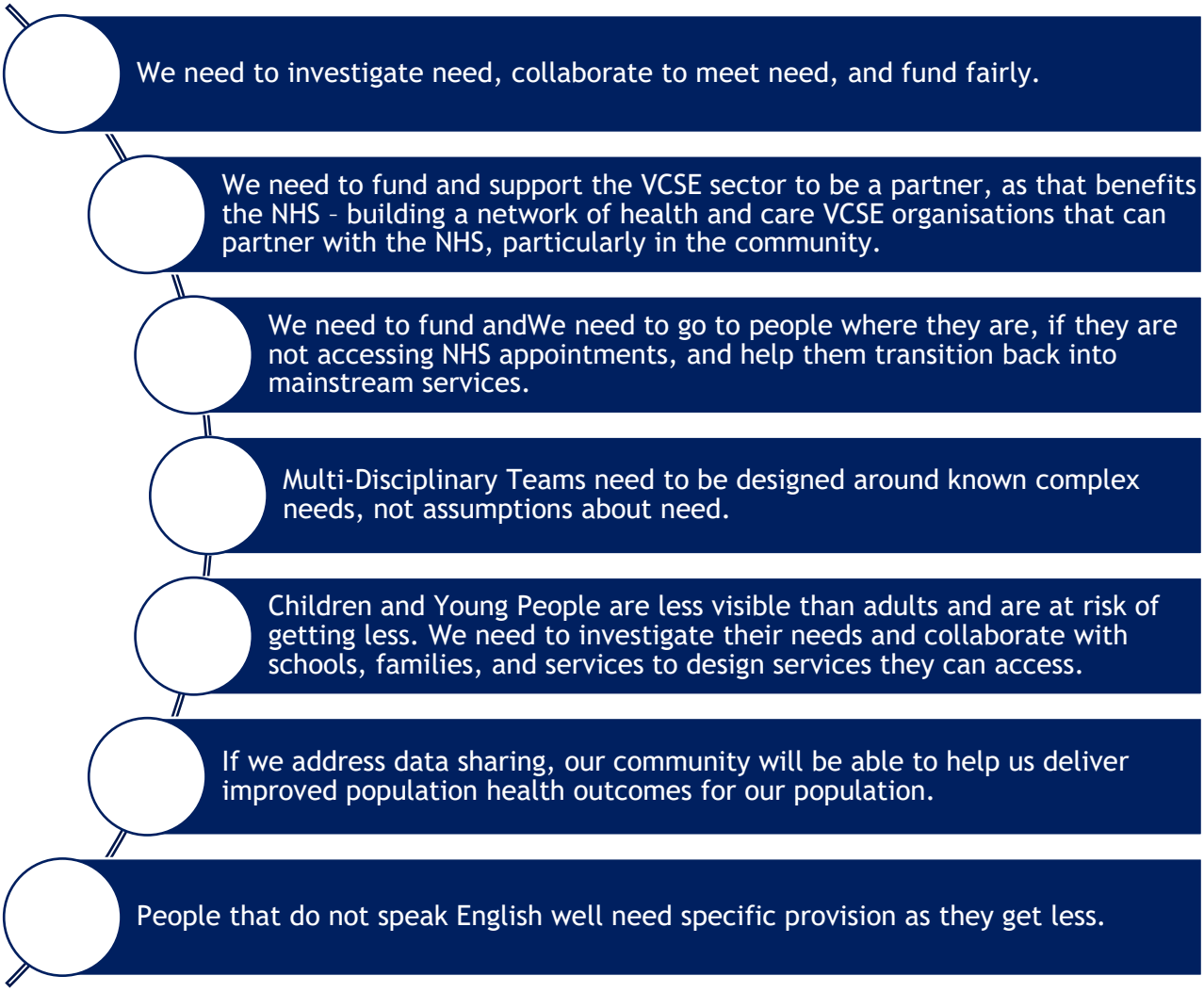
Gypsy Roma Travellers Health Improvement Programme - Gypsy, Roma and Traveller people experience significant inequalities across multiple areas of life or social indicators. Friends Families and Travellers (FFT) provide an assertive outreach service to all Gypsy, Roma, Traveller, and nomadic residents in East Sussex. Outreach team members

will visit community members on Local Authority-managed sites, Transit sites, Private sites, in bricks and mortar accommodation, roadside, emergency temporary accommodation settings and institutional settings, where appropriate. The team operate an asset-based community development model and provide casework support, advocacy support, specialist support for domestic abuse, benefits advice and support, form filling and healthcare advocacy. FFT also provide Outreach and Support for mental health and wellbeing on a 1:1 basis, in groups, via closed Facebook group platforms and at bespoke events. Training is also delivered though Royal Society of Public Health bespoke certified qualifications Level 1 and 2 in health awareness and improvement.

Geography

Universal Healthcare Hastings and St Leonards - The Universal Healthcare Network is led by London South Bank University (LSBU) and is comprised of a range of health and care leaders. It aims to make visible the reality of inequalities in service provision, and work through how best to secure services that are designed around health needs, in order to improve population health outcomes and reduce health inequalities.

In 2022, the network commenced an inquiry which was focused on testing how three propositions, which it had identified as contributing to unequal healthcare, could be addressed by co-creating and testing innovations with local communities. The three propositions were: Medicalising poverty and providing 'sticking plaster' approaches that, with the best intensions, make the problem of poverty invisible; providing services that are not accessible to all; and not being frank and open about the reality of the rationing of services. As part of this, LSBU was commissioned to establish an Innovation and change laboratory in Hastings over twelve months. The laboratory provided an environment for community members and professionals working in Hastings to come together over a series of workshops and use data on local healthcare services and access to them as the basis for co-creating twelve prototype initiatives which had the potential to make healthcare service provision fairer and more likely to reduce health inequalities. In early 2023, testing, refinement and evaluation was completed on eight of the initiatives, and this process provided the following learning:



In 23/24, seven of the prototype initiatives underwent further testing to better understand their potential impact on population health outcomes and inequalities, and shared system priorities, in particular the ambition to create Integrated Community Teams. Based on the key learning obtained through further testing, the following recommendations are suggested for those involved in developing and delivering Integrated community Teams across Sussex:

- ICTs should prioritise building relationships between stakeholders. This should be supported with appropriate infrastructure to facilitate effective collaboration and shared learning within their development and delivery in order to make them stronger.
- Those working as part of an ICT should be flexible and adaptable in their approach to community participation, organising events on different days and times, including

evenings and weekends, and offering multiple opportunities for people to provide feedback, including both digital and printed formats. They should not assume that social media is the answer.

- ICTs which develop digital product should ensure they reflect potential user's abilities rather than the latest technology. They should also include functions and features which are accessible to as many users as possible.
- ICTs should offer training to partners on the benefits of sharing data and how it can be done safely and in line with GDPR. They should also ensure that, when it comes to sharing data, the focus is on identifying the minimum amount that needs to be shared and the fewest people it needs to be shared with to ensure individuals get the support they need and GDPR is not a barrier to joined up proactive care and support.
- ICTs should consider their role in ensuring representation in our health and care workforce and addressing unemployment associated health inequalities by supporting people from local communities, especially those communities that are disadvantaged or marginalised, in pursuing careers in health and care

How do I look for health inequalities:

Some publicly available indicators will also have data for certain local inequality characteristics. OHID produce a document summarising all the PHOF indicators where they have provided inequality measures.

The following guidance has been developed to help identify what health inequalities there may be within your area of interest in East Sussex. The guidance includes a summary of what health inequalities are, a user guide for where you might look for information on both national and local health inequalities, and a template form to use to identify health inequalities locally.

Appendix 1 presents a case study of smoking prevalence and how this guide has been applied to identify where there may be inequalities, and where there is insufficient local data available and where further work is needed.

The following table is an extract from that case study and shows the key inequalities that may impact smoking prevalence, and what inequality data has already been published. Those inequality measures listed which do not have any information shown in the East Sussex or England columns still require further work to identify smoking prevalence in

relation to those measures. The case study in Appendix 1 explains what steps were taken to fill in those blanks.

Inequality Measure	East Sussex	England
Indices of Multiple Deprivation (IMD)	Mapping resources	Mapping resources
	Main data	Main data
Age	ONS	OHID/ONS
Sex	OHID	OHID
Employment status		OHID
Socio-economic	OHID	OHID
Health Status		OHID
Relationship status		ONS
Educational Attainment		ONS
Ethnic groups		OHID
Country of birth		OHID
Religion		OHID
Sexuality		OHID
Housing tenure	OHID	OHID
Children		
Pregnant women	ESHT/JSNA/OHID	OHID
Mental Health	OHID	OHID
Substance misuse	OHID	OHID

Local information on health and inequalities can be found on the East Sussex JSNA website. Our Joint Strategic Needs Assessment (JSNA) identifies the current and future health and

wellbeing needs and strengths of local communities. These resources help to inform decisions and plans to improve local people's health and wellbeing and reduce health inequalities in East Sussex:

- Tools and resources
- Local briefings and needs assessments

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

OHID Health Inequalities tools

- COVID-19 Health Inequalities Monitoring for England tool (CHIME)
- Health Inequalities Dashboard
- Segment Tool
- Public Health Outcomes Framework
- Local Health
- Local Inequalities Explorer Tool
- Spotlight Tool

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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] PHE (2021) Addressing health inequalities through collaborative action Briefing note Office for Health Improvement and Disparities

[5] Inclusion Health: applying All Our Health - GOV.UK

[6] 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

[7] 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

[8] NHS England (2023) A national Framework foe NHS – action on inclusion health https://www.england.nhs.uk/long-read/a-national-framework-for-nhs-action-on-inclusion-health/

[9] https://fingertips.phe.org.uk/profile/tobacco-control/supporting-information/smokingandinequalities

[10] Ethnicity Coding in English Health Service Datasets - NHS – Race and Health Observatory (nhsrho.org)

[11] 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

[12] https://www.health.org.uk/news-and-comment/blogs/tackling-health-inequalities-how-the-government-can-do-things-differently

[13] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/825133/Tool_A.pdf