

Director of Public Health
Annual Report 2010/11
Summary



Reducing Health Inequalities in East Sussex



East Sussex Downs & Weald PCT

Hastings & Rother PCT

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This is the fourth annual public health report for NHS East Sussex Downs and Weald, NHS Hastings and Rother and East Sussex County Council, and is aimed at those working to improve health and wellbeing and reduce inequalities in East Sussex. It describes the current position on health inequalities across East Sussex and the work being undertaken to reduce them, and uses national evidence, including that from the Marmot Review, to provide recommendations for joint work to reduce health inequalities and improve health for East Sussex residents. I hope this will be a useful resource to encourage us all to keep working towards this goal.

This report is designed to highlight the key messages and recommendations. If you would like more information you can refer to the online report for more in-depth analysis of the data, information about evidence-based interventions and discussion of local needs. We've used the figure numbering from the online report in this summary so that you can easily refer back to the online report to find out more. Information online is presented so that it can be easily identified and extracted to produce local authority-level health inequality profiles and is available on the PCTs websites:

www.esdw.nhs.uk

www.hastingsandrother.nhs.uk

I would like to take this opportunity to thank all of those who made contributions to the report:

Tracey Baldock-Apps
Joanne Bernhaut
Jennifer Broome-Smith
Sophie Clark
Jean Costello
Anita Counsell
Anne Cross
Graham Evans
Sara Folwell
Clare Harmer
Hazel Henderson
Jennifer Hopkin

Adam Horvath
Alison Jeffery
Cynthia Lyons
Maurice Marchant
Jacqueline Nash
Sheila O'Sullivan
Stuart Ramsbottom
Stuart Russell
Louise Sigfrid
Sue Talbot
Jane Thomas
Richard Watson



Diana Grice
Director of Public Health and Medical Director
NHS East Sussex Downs and Weald
and NHS Hastings and Rother

Executive Summary

A brief overview of each chapter of the online report, is provided below:

Chapter 1 explores health inequalities. We also discuss what causes them and why tackling them is important. This chapter identifies some of the key data and methods used to quantify health inequalities presenting the current position using those measures. District and borough level information is presented in tables, charts and maps.

Recommendation: It is recommended that both sophisticated and simple measures for health inequalities are used, with a clear understanding of the parameters of each measure.

A particular focus of **Chapter 2** is the identification of the main contributors to the gap in life expectancy between the most and the least deprived areas. At an East Sussex level, circulatory diseases, cancer and respiratory diseases are the top three contributors, but at the district and borough level, there is some variation.

This chapter presents the main causes of the life expectancy gap for each district and borough and what the possible gain in life expectancy in the most deprived areas would be if, for specific diseases, the death rates were the same as the least deprived areas. For example, in Eastbourne, if the rates of death from heart disease in the most deprived areas of Eastbourne were brought down to the same levels as they are in the least deprived areas, there would be a 1.3-year increase in life expectancy for men.

Key information from the Joint Strategic Needs Assessment Programme is also included in this chapter, comprising: profiles for each district and borough based on the latest Joint Strategic Needs Assessment Scorecards; details of comprehensive needs assessments; and focused work on increasing life expectancy within the twenty wards with the lowest life expectancy.

Recommendation: The Joint Strategic Needs Assessment programme should be maintained and developed further to ensure a shared evidence base, to support commissioning, to improve health and wellbeing outcomes and reduce inequalities.

Chapter 3 describes some of the work we are currently doing to tackle health inequalities. It explains our local approach to promoting health in the five priority areas: alcohol; smoking and tobacco control; obesity; sexual health; mental health and wellbeing. Circulatory diseases, cancer and respiratory diseases are the top three contributors to the gap in life expectancy and so work being done to reduce these is described. Also included in this chapter are sections with a particular focus on children and young people and older people.

Recommendations:

Promoting Healthy Lifestyles

1. Review health improvement strategies and action plans to ensure that these incorporate the findings of this report, recent needs assessments and new policy guidance.
2. Review commissioning for health improvement to ensure that interventions are evidence-based, cost-effective and prioritise the needs of the most vulnerable, to reduce health inequalities, and that there is improved access to health improvement services especially in deprived areas.

Top 3 Causes of the Life Expectancy Gap

1. It is recommended that work continues to reduce variation in the identification, treatment and support provided to address: hypertension; high cholesterol; atrial fibrillation; poorly controlled blood sugars; and chronic obstructive pulmonary disease (COPD).
2. The NHS Health Checks Programme commenced in 2009/10 in parts of East Sussex and now needs to be extended.
3. Further work to improve cancer survival at one year is needed, especially among lower income groups and men. This should be informed by the evaluation of the PCTs' National Cancer Awareness and Early Diagnosis Initiative (NAEDI) funded campaigns.

Children and Young People

1. Ensure that tackling inequalities is a core theme within the Children and Young People's Plan – the overarching plan to improve health and wellbeing outcomes for children and young people.

Older People

1. The Joint Commissioning Strategy, 'Living Longer, Living Well' is designed to meet both existing and future health, social care and housing support needs for adults in later life and their carers. The lead commissioning agencies for this strategy, East Sussex County Council's Adult Social Care Department and the PCTs, should ensure implementation.
2. The services commissioned for older people across health and social care should be balanced between locating them in areas of greatest concentration of older people and also targeting those groups of older people who are likely to be in greatest need – socially isolated, income deprived and aged over 85 years.

The final chapter, **Chapter 4**, proposes the next steps for further reducing health inequalities in East Sussex. We've considered national best practice and key things that are expected to make an impact in a short timescale if delivered at a sufficient scale. A main focus here is on improving the quality of general practice.

Health inequalities result from social inequalities and reducing them requires action across the wider social determinants of health. An important landmark for public health was the publication of the Marmot Review in 2010¹, which concluded that reducing health inequalities will require action in six key areas:

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

The final chapter outlines Marmot's framework for action and those actions that are expected to make an impact in the medium- to long-term.

Recommendations:

1. The ten major lessons learned by the Health Inequalities National Support Team (HINST) should inform work to reduce health inequalities in East Sussex by using programme-based delivery and the HINST diagnostic model for interventions.
2. Improving the quality of primary care is one of the key factors to reducing health inequalities and it is recommended that the following actions are taken:
 - a) A GP Practice Balanced Scorecard, including specific metrics to reduce health inequalities, should be implemented.
 - b) Develop an ongoing programme of general practice chronic disease management audits using a z-score-based dashboard and focusing on the key life expectancy gap contributory care pathways, such as coronary heart disease (CHD), cancer and chronic obstructive pulmonary disease (COPD) care.
 - c) A system should be developed to group general practices with similar populations to enable like-with-like comparisons.
3. An East Sussex Health Inequalities Implementation Plan needs to be developed to implement the Marmot Review and the recommendations outlined in this report.

¹ Marmot M. *Strategic Review of Health Inequalities in England Post-2010*. Marmot Review Final Report, University College London, 2010.

The NHS White Paper, *Equity and Excellence: Liberating the NHS*, published in July 2010, sets out the new Government's ambitious plans to reform the NHS. So, from 2012, responsibility for health improvement will transfer from the East Sussex PCTs to East Sussex County Council and the Director of Public Health post will be a joint appointment between East Sussex County Council and the National Public Health Service.

These changes will bring many opportunities for us to work in partnership to take forward the recommendations from this report to reduce health inequalities in East Sussex. There are a number of factors that need to work together for us to make a difference in health inequalities. These include:

Strong leadership and partnerships

East Sussex organisations take a strong partnership approach to tackling the root causes of ill health and health inequalities. There is a lot of shared information and understanding about how health varies across the county and about the relationship between health outcomes and key risk factors. Funding for public services is likely to be reduced annually over the coming years. Working in partnership and seeking to deliver efficiency savings will help to manage these reductions.

Tackling the wider determinants of health

There are six Local Strategic Partnerships (LSPs) in East Sussex, one for each district or borough area and one for the whole county area, and their membership includes key organisations such as the PCTs, Police, fire and rescue service, businesses, voluntary and community groups, county, district, borough and parish councils.

The LSPs have worked together to produce an integrated Sustainable Community Strategy for East Sussex called 'Pride of Place'. Pride of Place covers the period 2008–2026; it is a long-term plan to achieve a better quality of life for all local people and reducing inequalities and narrowing the gap is at the heart of this strategy. This has also been carried through into our Local Area Agreement (LAA) which is the agreement between local partners and central Government on which national priorities are also key local priorities for East Sussex.

Supporting healthy lifestyles

Increasingly, East Sussex organisations have been using social marketing techniques to help support people to live more healthy lifestyles. Social marketing is a method of identifying the best way in which health related messages, support and services can be targeted to meet the needs of particular groups and communities. An emphasis on using social marketing techniques and local health data, as well as working with local people and learning from successful approaches means that interventions are evidence-based, targeted at those with the greatest need and shaped to meet the needs of local people.

Providing services which make a difference

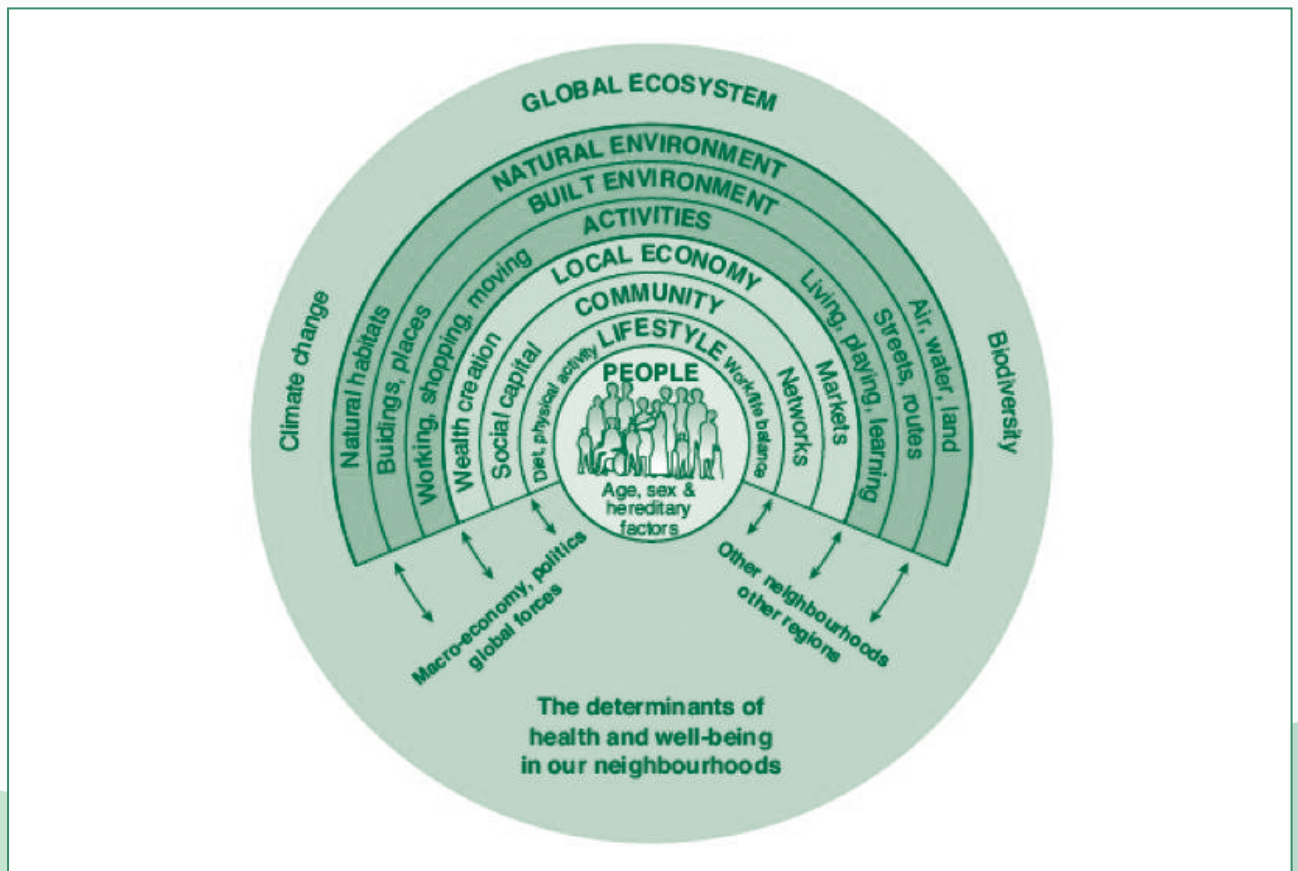
There has been determined effort to improve standards in primary care, and to work towards improved practice. The national Quality and Outcomes Framework has helped drive up standards. Multi-disciplinary clinical groups have been working with social care colleagues on agreed ways to improve outcomes by redesigning pathways of care.

There is good partnership working in East Sussex and improvements are being made to people's health and wellbeing. This is a strong basis for achieving further reductions in health inequalities by implementing national best practice and the recommendations from this public health report.

What's Important about Health Inequalities?



Figure 1: *The main determinants of health*



Source: Barton H and Grant G (2006) adaptation of Dahlgren G and Whitehead M (1991) from UN Economic Commission for Europe (2007), Resource Manual to Support Application of the Protocol on Strategic Environment Assessment.

Inequalities in health are differences in health status between population groups. They are associated with many different factors, both at an individual and population level.

The determinants of health are presented above in the updated version of the well known diagram by Dahlgren and Whitehead² that appeared in the Acheson Inquiry Report³ (Figure 1). It shows that there are many determinants of health and these can be grouped into layers of influence. These different layers of influence do not operate in isolation, but interact in complex relationships. Some determinants of health such as age, gender and genetic make-up, are fixed and little can be done to change them.

Other determinants such as individual lifestyle factors, social and community networks, socioeconomic, cultural and environmental conditions are amenable to change – they are modifiable. Most influences on health show a ‘social gradient’, where conditions that are beneficial to health are less favourable with declining social status – the lower a person’s social position, the worse his or her health.

The consequences of the recession on health and wellbeing will be felt for some time. The most vulnerable are often first to suffer. People who lose their job are around three times more likely to experience a common mental health problem than those who remain employed.

² Dahlgren G and Whitehead M. *Policies and Strategies to Promote Social Equity in Health*. Stockholm, Institute for Future Studies, 1991.

³ Independent Inquiry into Inequalities in Health (Acheson Inquiry). Report of the Independent Inquiry into Inequalities in Health, 1998.

Why Addressing Health Inequalities is Important

Health inequalities do not arise by chance and are not just down to genes, unhealthy behaviour or differences in access to services, important as those factors may be. Social and economic differences in health status reflect, and are caused by, social and economic inequalities in society. These social and economic inequalities underpin the determinants of health.

Health inequalities that are preventable are unfair and putting them right is a matter of social justice.

The cost of health inequalities can be measured in human terms; years of life lost and years free of disability lost, and in economic terms; by the cost to the economy of additional illness. It is estimated that inequality in illness accounts for productivity losses of £31–33 billion per year, lost taxes and higher welfare payments in the range of £20–32 billion per year, and additional NHS healthcare costs associated with treating inequality are in excess of £5.5 billion per year.

Life expectancy at birth is an indicator of the overall health of the population. A longer life expectancy reflects better health. People living in the more deprived areas will, on average, die earlier than people living in the more affluent areas. Equally disturbing is that people living in the more deprived areas will, on average, have less disability-free life expectancy than people living in the more affluent areas.

So people in more deprived areas not only die sooner, but they will also spend more of their shorter lives with a disability.

This picture exists in East Sussex at present. Tables 1 and 2 present the Index of Multiple Deprivation Score, average life expectancy at birth, and disability-free life expectancy at district/borough level.

Life expectancy and disability-free life expectancy is presented for 2001 as disability-free life expectancy is based on a 2001 Census question and cannot be updated until the 2011 Census.

Hastings has the highest deprivation score, the lowest life expectancy at birth and the lowest disability-free life expectancy for both males and females.

Table 1: *Life Expectancy and disability-free life expectancy among males at birth, 2001*

	Index of Multiple Deprivation 2007 Score	Life Expectancy (yrs)	Disability-free life expectancy (yrs)	Difference (yrs)
Eastbourne	23.36	75.3	61.2	14.1
Hastings	32.21	74.2	58.3	15.9
Lewes	14.79	78.7	65.1	13.6
Rother	17.85	77.4	63.5	13.9
Wealden	10.86	78.3	66.0	12.3

Note: The higher the Index of Multiple Deprivation Score the more deprived.

Table 2: *Life Expectancy and disability-free life expectancy among females at birth, 2001*

	Index of Multiple Deprivation 2007 Score	Life Expectancy (yrs)	Disability-free life expectancy (yrs)	Difference (yrs)
Eastbourne	23.36	81.7	65.2	16.5
Hastings	32.21	79.6	62.2	17.4
Lewes	14.79	82.3	66.8	15.5
Rother	17.85	81.4	66.3	15.1
Wealden	10.86	83.1	68.5	14.6

Note: The higher the Index of Multiple Deprivation Score the more deprived.

How do you Measure Health Inequalities?

There are many ways of measuring health inequalities that range from using different data sources, different geographies and different methods for comparison.

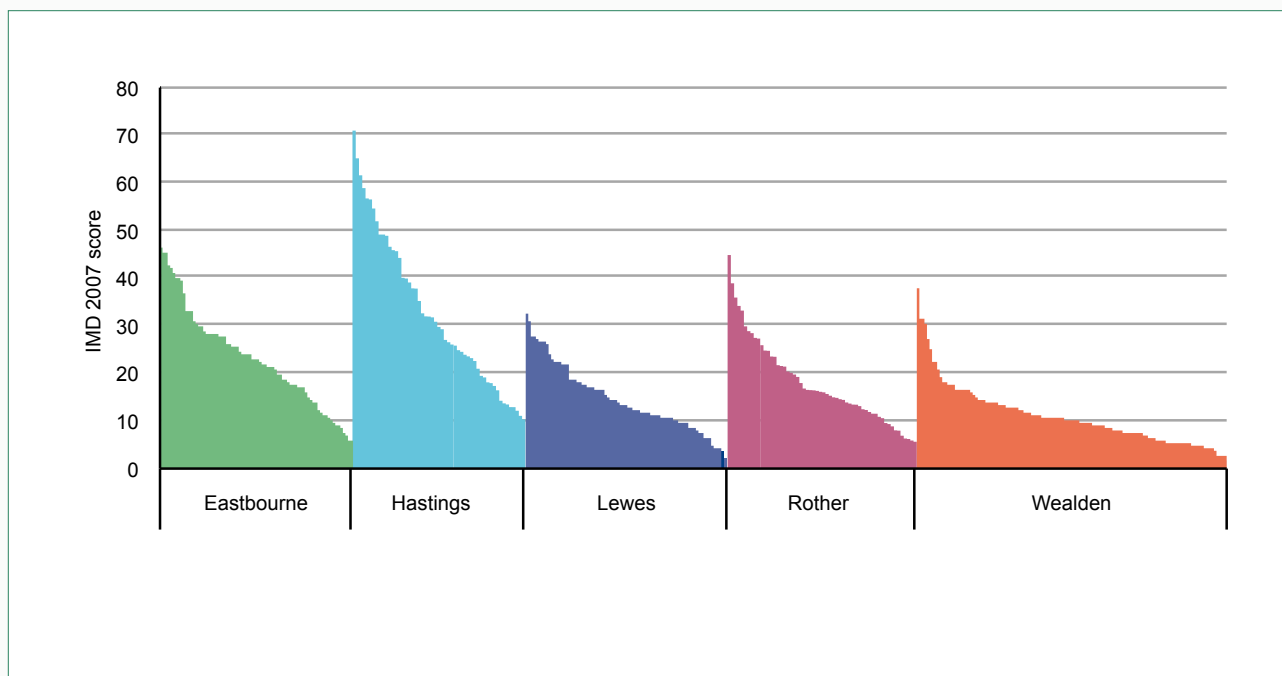
The key measures, how they are worked out, and how East Sussex looks when reviewed using these methods is included. There is much more detail about the measurement tools, the results in East Sussex, and how to interpret the graphs and charts available in the online report.

The report includes a range of graphs and maps to quantify health inequalities and present the current position using the measures described. All the maps and figures show wide variation at district/borough, ward or Local Super Output Area (LSOA).

1 / What's Important about Health Inequalities?

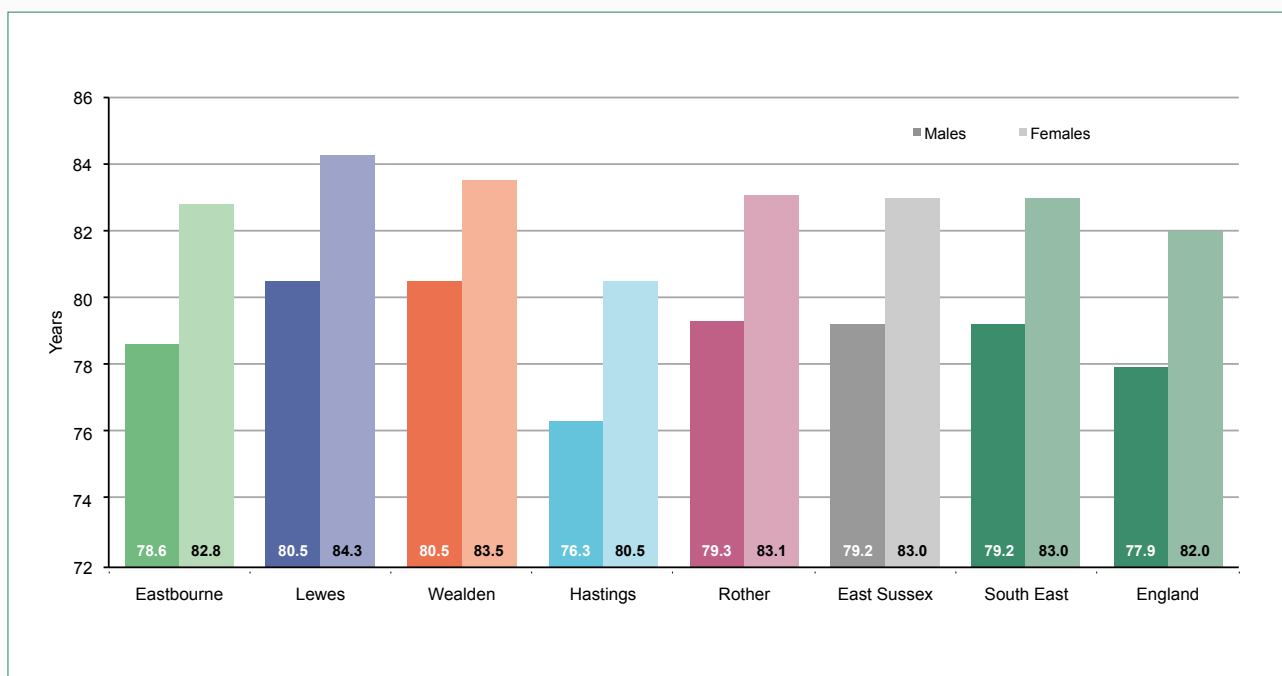
Name of measure		What is it?	What are the East Sussex district / borough / PCT level results?	Figure which displays this measure in the online report
Index of Multiple Deprivation 2007 (IMD 2007)		A number of markers are combined to give areas a deprivation score enabling them to be ranked against each other (lower scores = less deprived / higher ranking = most deprived). The areas used are called Lower Super Output Areas (LSOAs).	Range 10.9 – 32.2	Figures 4 and 5
National health inequalities targets (from the NHS Plan, 2000)	Infant mortality	The infant mortality rate measures the number of deaths to babies under one year per 1,000 live births in an area.	Range 2.9 – 6.4 deaths under one year per 1,000 live births. East Sussex = 5.1 per 1,000 live births.	Figures 6 and 7
	Life expectancy	Life expectancy at birth is the average number of expected years of life remaining. Therefore it is not the number of years someone in the area in that time period is actually likely to live (both because the death rates of the area are likely to change and because people may live in other areas for at least part of their lives).	Men = Range 76.3 – 80.5 years Women = Range 80.5 – 84.3 years	Figures 8, 9, 10, 11, 12, 13, 14, 15 and 16
All age cause mortality		This indicator is an alternative for life expectancy, and includes death from all causes.	NHS ESDW Males – 575.9 Females – 467.5	Figures 17, 18 and 19
Slope Index of Inequality		Slope Index of Inequality (SII) for life expectancy at birth, calculated by grouping LSOAs into deciles based on the IMD score of each LSOA. This represents the gap in years of life expectancy between the most and least deprived within the PCT, split for males and females.	NHS ESDW Males – 6.5 years Females – 4.2 years NHS H&R Males – 9.5 years Females – 7.5 years	Figures 20, 21, 22, 23, 24 and 25
Vital signs targets	Cancer mortality	To reduce the mortality rate by 2010 for cancer by at least 20 per cent in people aged under 75 years, with a reduction in the inequalities gap of at least 6 per cent between the fifth of areas with the worst health and deprivation indicators and the population as a whole.	NHS ESDW – 101.0 NHS H&R – 120.7 Per 100,000 directly age standardised	Figure 26
	Circulatory diseases mortality	To reduce the mortality rate by 2010 for heart disease, stroke and related diseases by at least 40 per cent in people aged under 75 years, with a 40 per cent reduction in the inequalities gap between the fifth of areas with the worst health and deprivation indicators and the population as a whole	NHS ESDW – 52.9 NHS H&R – 68.1 Per 100,000 directly age standardised	Figures 27 and 28
Rural / Urban		Gives us a breakdown of the areas based whether they are urban, town and fringe or more isolated (more rural)	Urban areas average almost a year's less life expectancy than East Sussex as a whole and almost two and a half years less than areas classed as town and fringe, and village, hamlet and isolated dwellings.	Figures 29, 30 and 31

Figure 4: Index of Multiple Deprivation 2007 scores by LSOA grouped by East Sussex districts and boroughs



Source: Index of Multiple Deprivation 2007

Figure 10: Life expectancy at birth, East Sussex districts and boroughs, 2006–2008



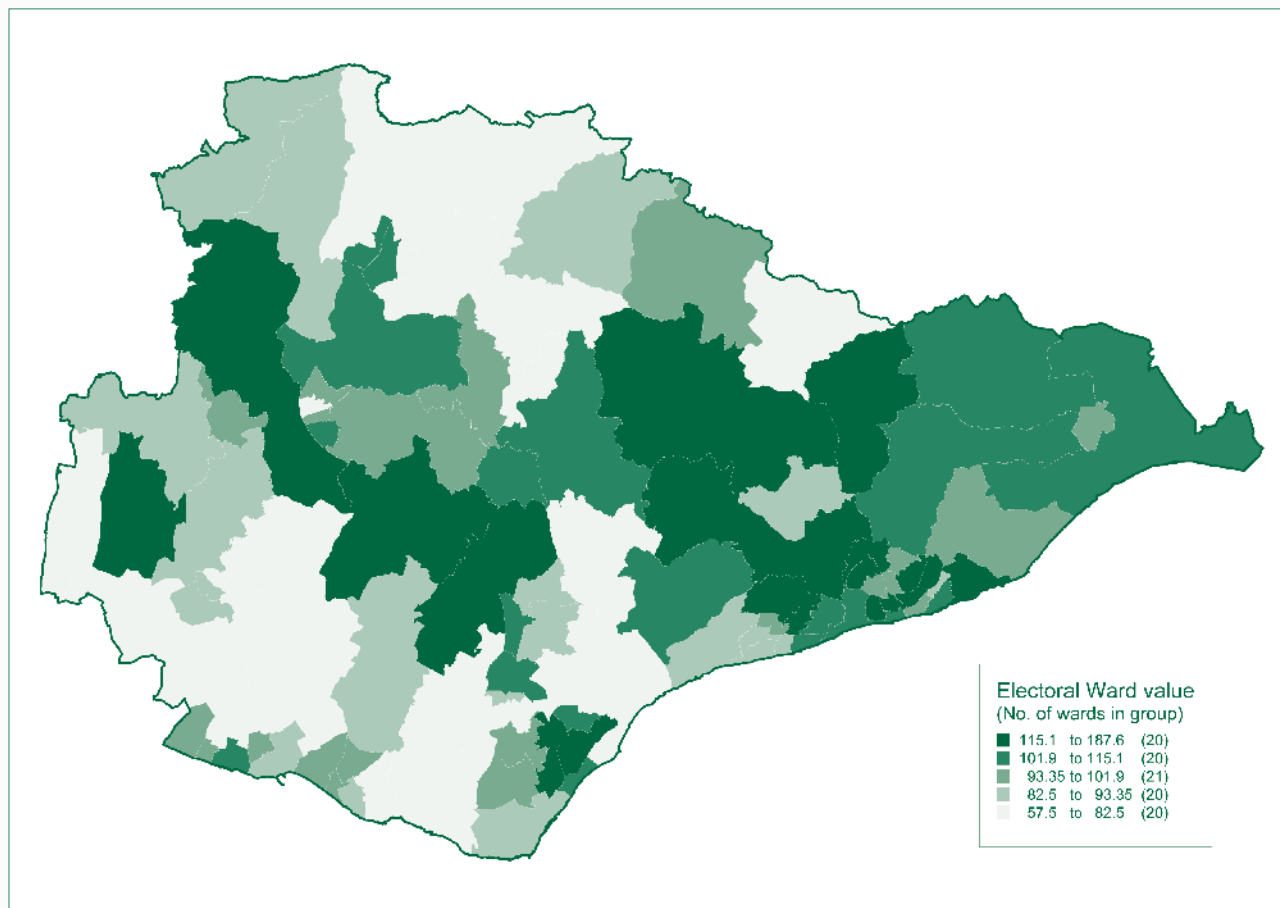
Source: Compendium of Clinical and Health Indicators

For instance, Figure 4 shows the wide variation of IMD 2007 scores across the LSOAs by district.

The latest life expectancy at birth figures are presented in Figure 10 above, which show that Hastings has the lowest life expectancy for males and females and is the only area where life expectancy is below the national average.

1 / What's Important about Health Inequalities?

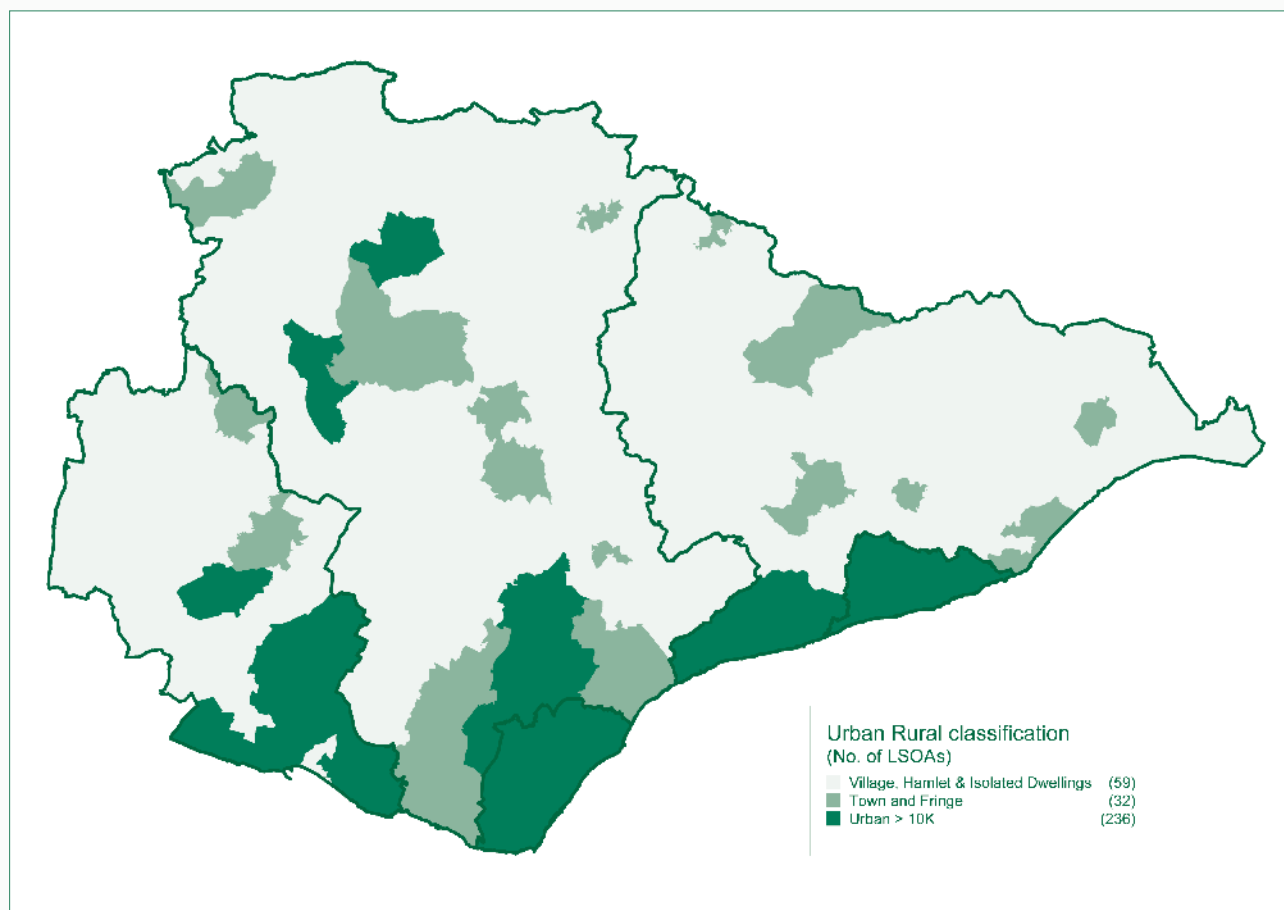
Figure 19: *All age all cause standardised mortality ratios, East Sussex electoral wards, 2005–2007 (East Sussex = 100)*



Source: ONS mortality data

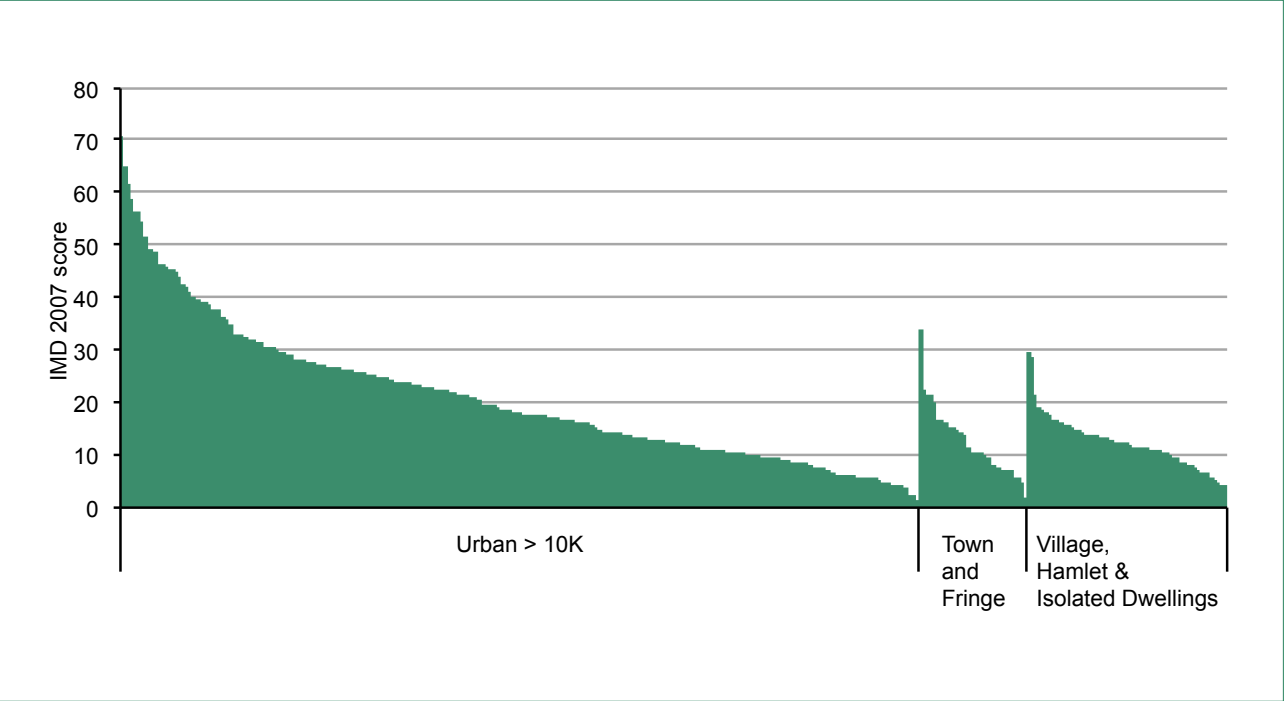
Figure 19 maps all age all cause mortality ratios at ward level and clearly shows the wards where deaths are higher than expected.

Figure 29: Rural / Urban classification by lower super output area in East Sussex



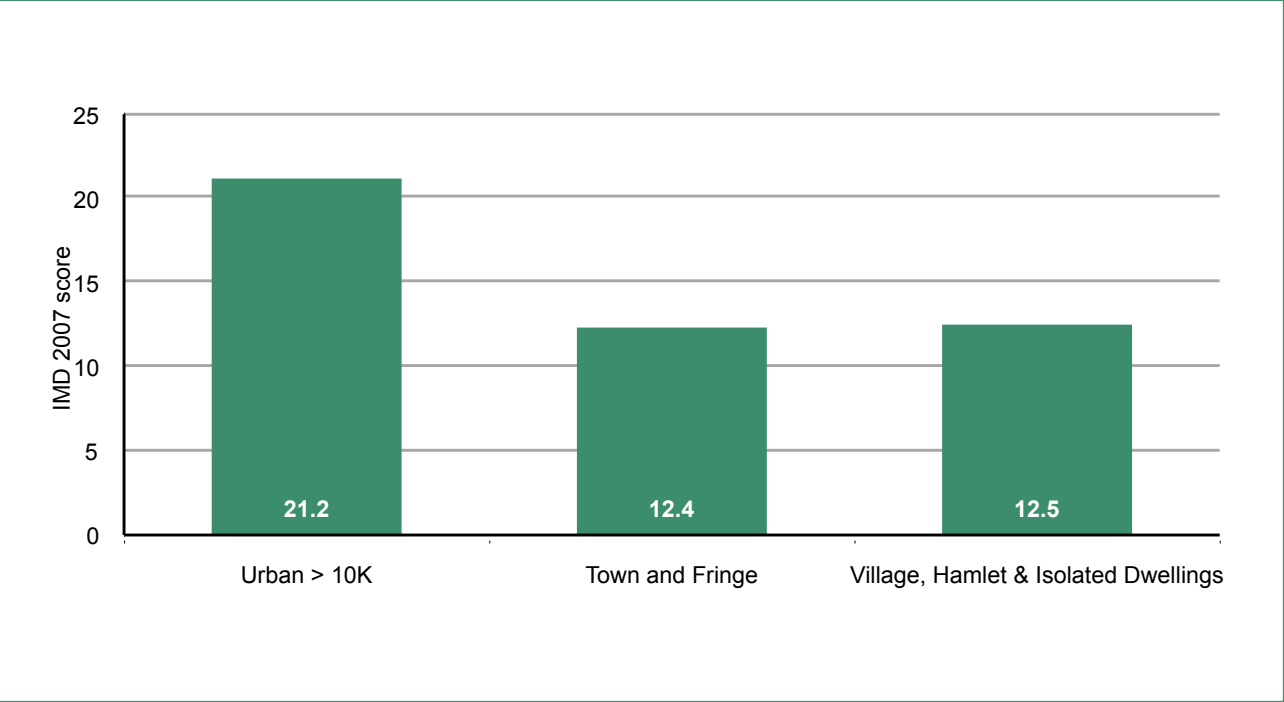
The map above identifies the areas classified by the Office for National Statistics as urban and rural.

Figure 30: Index of Multiple Deprivation 2007 scores at LSOA level by urban / rural classification in East Sussex



Source: IMD 2007 and Rural and Urban Classification 2004

Figure 31: Average IMD scores for urban and rural areas in East Sussex



Source: IMD 2007 and Rural and Urban Classification 2004

Figure 30 shows the range of deprivation scores at LSOA level within each of the classifications, showing that within each classification there are wide ranging scales of deprivation experienced by populations.

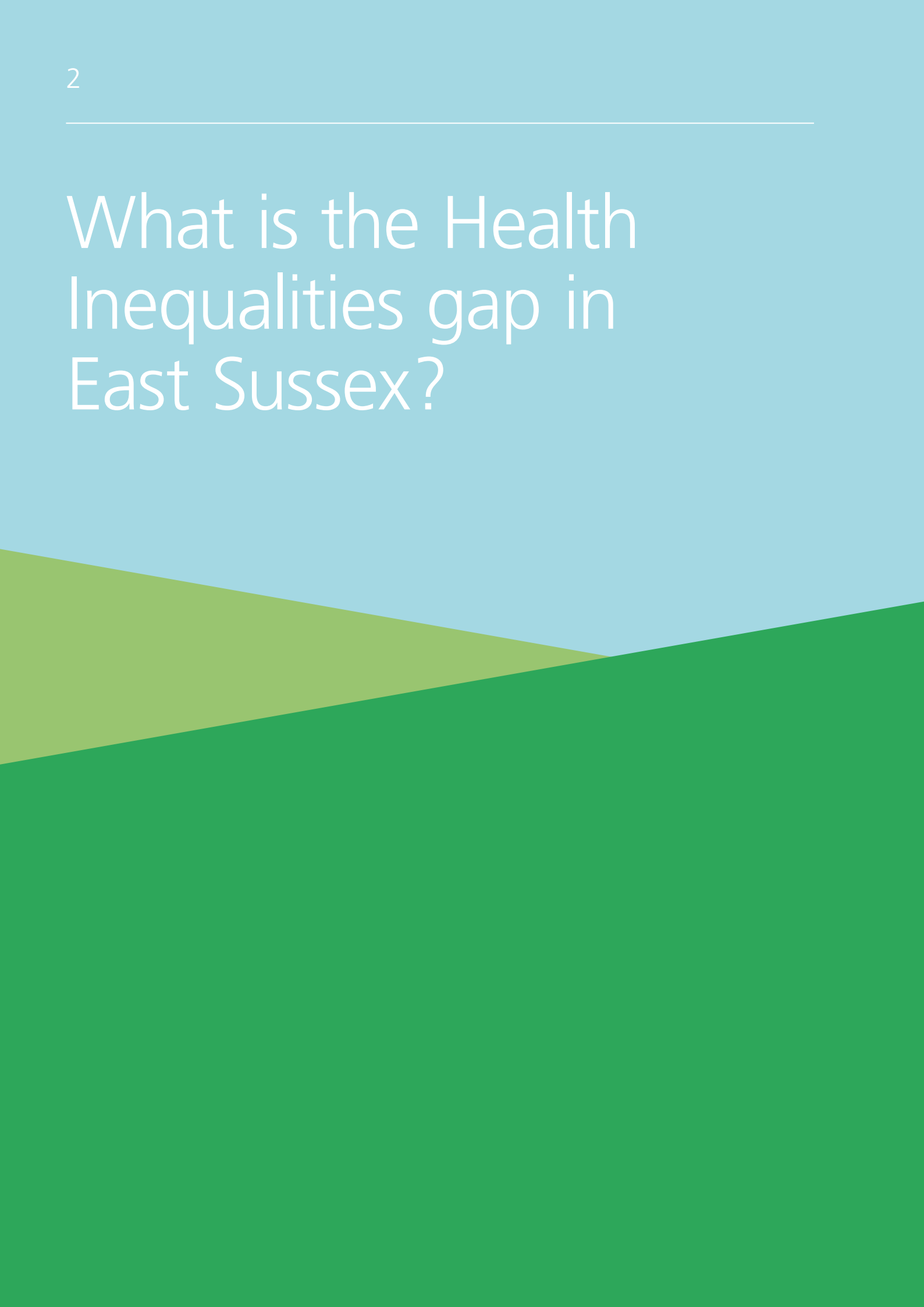
When you calculate overall deprivation scores for these areas there is a clear difference between the 'urban' populations over 10,000 and the other two categories.

Calculating life expectancy for each area of classification, it shows that the population in urban areas average almost a year's less life expectancy than that experienced by the whole of East Sussex and almost two and a half years less than areas classified as town and fringe.

Recommendations

1. It is recommended that both sophisticated and simple measures for health inequalities are used with a clear understanding of the parameters of each measure.

What is the Health Inequalities gap in East Sussex?

The background of the slide features a light blue upper section and a lower section composed of two overlapping green shapes. On the left, a light green triangle points towards the right. Overlapping its right side is a darker green shape that slopes upwards from left to right, creating a layered, landscape-like effect.

Main Contributors to Life Expectancy Gap

This chapter reviews health inequalities that exist in East Sussex and in its districts and boroughs. We have also produced profiles for each district and borough with information about the demographic, needs and inequalities in each of those areas which are available on the websites as a resource for anyone working to design or deliver services in those areas.

Circulatory diseases, cancer and respiratory disease are the three top causes of the life expectancy gap between the most deprived and the least deprived at an East Sussex level.

East Sussex

At a district/borough level, circulatory diseases are the largest contributor to the gap in life expectancy in three local authorities for males and females. Mortality from external causes is the largest contributor to the gap in males for two districts. Cancers are the largest contributor to the life expectancy gap in females in just one borough.

Across East Sussex, mortality from circulatory diseases is higher in the most deprived quintile compared to the least deprived in ages 35–80 years, with significantly higher rates in those aged 45–79 years. Higher mortality rates from CHD can be seen across all ages with the most deprived areas of East Sussex having significantly higher rates in those aged 45–49 and 55–79 years. Mortality from all cancers, as well as specifically lung cancer is higher in the most deprived areas across the majority of ages, with lung cancer being significantly higher in those aged 50–54 and 60–74 years. There are significant differences in mortality from respiratory conditions between the most and least deprived areas in those aged 50 years and over for all respiratory conditions, in those aged 60 years and over for mortality from bronchitis, emphysema and COPD, and in those aged 75–79 years for mortality from pneumonia.

Deprivation

Hastings is the most deprived district with a score of 32.21 – almost twice as deprived as the county average of 18.78. Eastbourne is the second most deprived district, which is significantly less deprived than Hastings with a score of 23.36. Wealden is the least deprived district (over three times less deprived than Hastings) with a score of 10.86.

The other measures of deprivation follow the same pattern of deprivation shown by the index of multiple deprivation, with the exception of the housing and services deprivation score, where Eastbourne and Wealden have higher scores than Hastings.

Nearly three in ten (28.0%) households are on low income in Hastings, which is defined as less than 60% of national median income. This reduces to one in four for Eastbourne and Rother (26% & 25.8%). For Lewes and Wealden it is one in five (21.7% and 19.5%).

Lifestyles

78% of mothers start breastfeeding in East Sussex, but this falls to 52% at six to eight weeks of age. Wealden and Lewes have 59% breastfeeding fully or partially at six to eight weeks but in Hastings this falls to 44%.

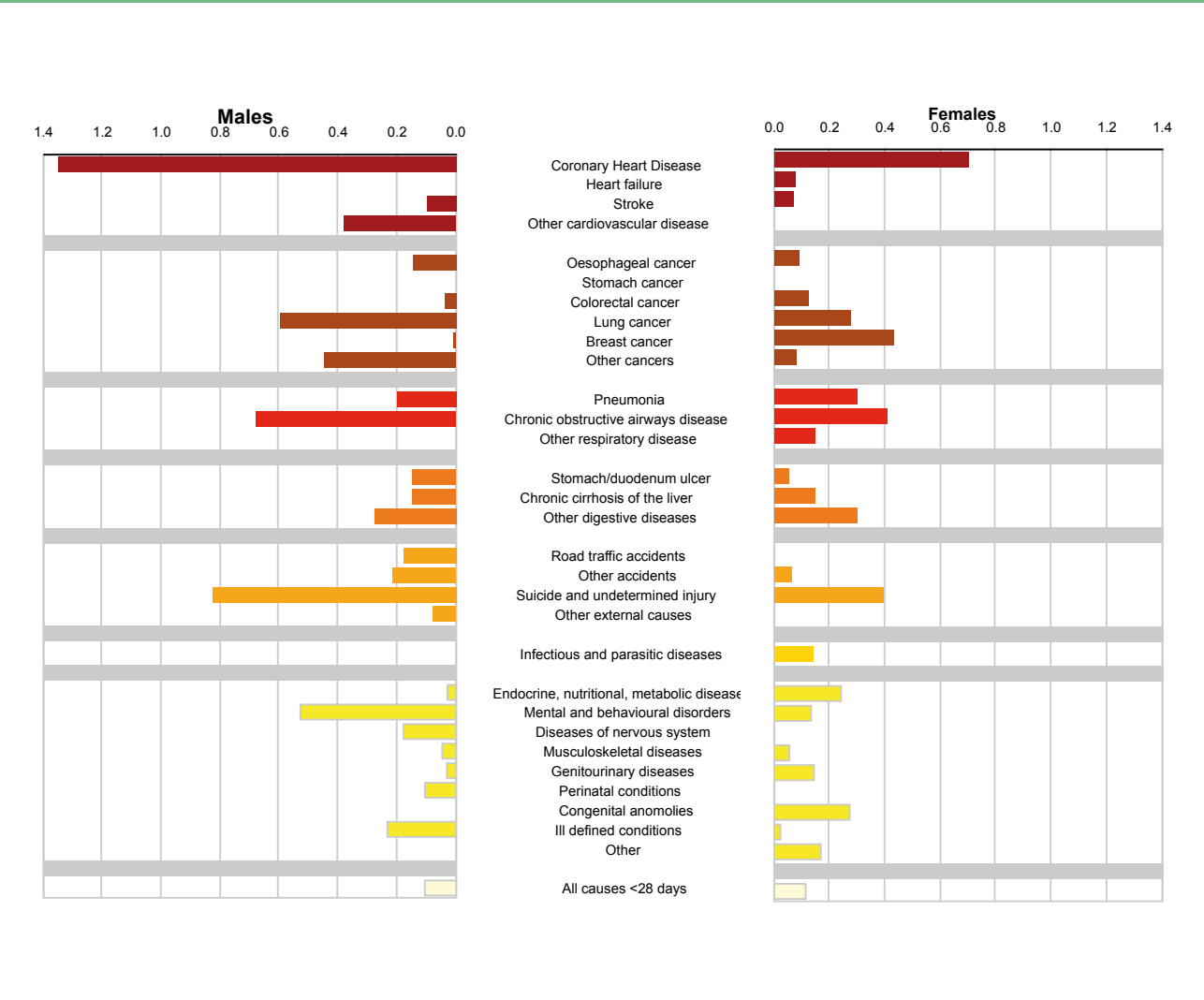
One in five (20%) of East Sussex reception year children are overweight or obese. This rises in Lewes to nearly one in four (24%). The figures for year 6 pupils for East Sussex is 28% with one in three (33%) of year 6 pupils in Rother. For adults there is only one in five (20%) who participate in sport and active recreation. The estimated adult level of obesity for the county is 22%.

Nearly one in five (18%) mothers are known to be smoking at the time of delivery. This rises significantly to 27% for Hastings.

Life expectancy

Life expectancy at birth in East Sussex is 81 with Wealden having the highest at 83 years compared to 79 years for Hastings. In East Sussex life expectancy is 20 years at aged 65.

Figure 34: Possible gain in life expectancy in Eastbourne (in years)

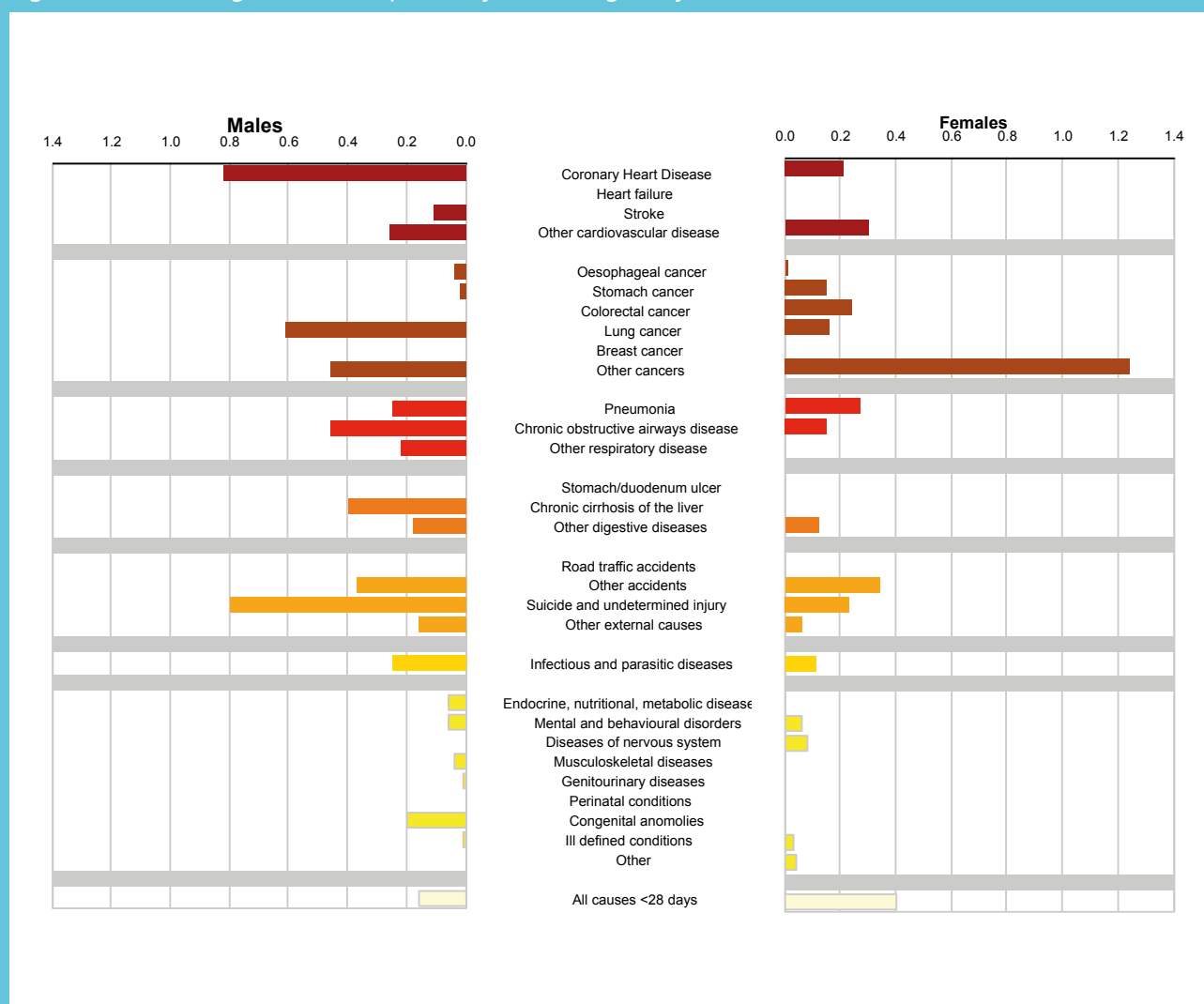


Source: London Health Observatory

In 2001–2005, the life expectancy gap for males was 6.2 years and for females 0.7 years between the most and least income deprived quintiles in Eastbourne. A quarter of the gap in life expectancy in males is due to circulatory diseases (26%), whereas in females circulatory diseases accounts for 17% of the gap with all cancers and ‘other’ contributing more (20% and 21% respectively). Please see figure 33 in the online report.

Further analysis of the gap in life expectancy (Figure 34), shows that for both males and females, the largest possible gain in life expectancy in the most deprived areas is from CHD, with a gain of around 1.3 years for males and 0.7 years for females if they had the same mortality rate as those in the least deprived areas. In males the next largest possible years of life gained are from suicide and COPD (0.83 and 0.68 years respectively). In females, it’s breast cancer (0.43 years) and COPD (0.41 years).

Figure 36: Possible gain in life expectancy in Hastings (in years)

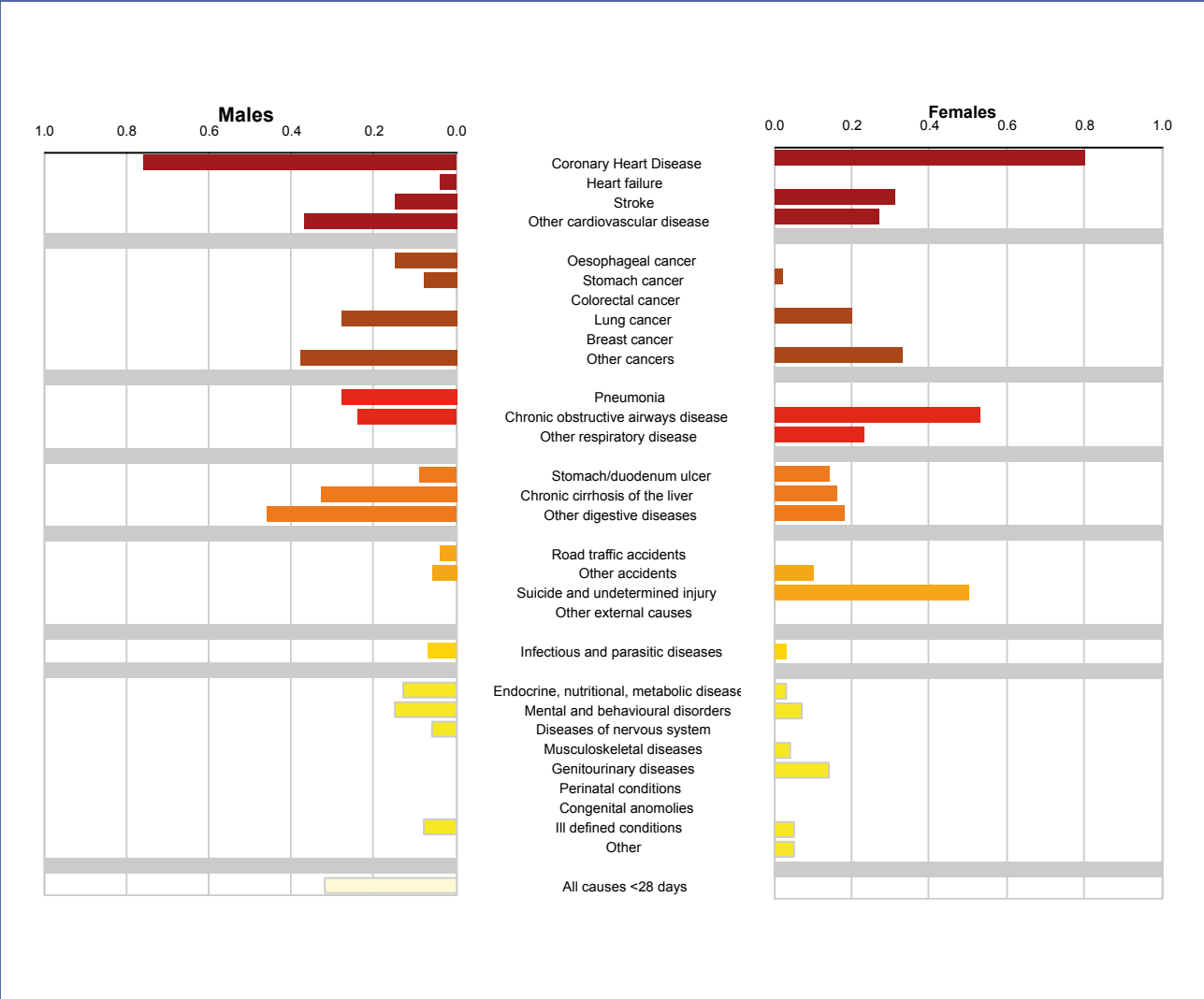


Source: London Health Observatory

In 2001–2005, the gap in life expectancy in males was 5.5 years and in females 2.3 years between the most and least income deprived in Hastings. The main contributors to the life expectancy gap in males are external causes (22%), circulatory diseases (20%) and cancers (19%). In females a large part of the life expectancy gap is due to cancers (43%). Please see figure 35 in the online report.

Breaking down the life expectancy gap further shows that the years of life that could be gained for males in the most deprived areas of Hastings are largest for CHD (0.82 years), suicide (0.8 years) and lung cancer (0.61 years) (Figure 36). In females the largest gain would be from ‘other cancers’ (excludes oesophageal, stomach, colorectal, lung and breast cancers), where there could be a gain of 1.24 years, if females in the most deprived areas had the same mortality rates as those from the least deprived areas in Hastings.

Figure 38: Possible gain in life expectancy in Lewes (in years)

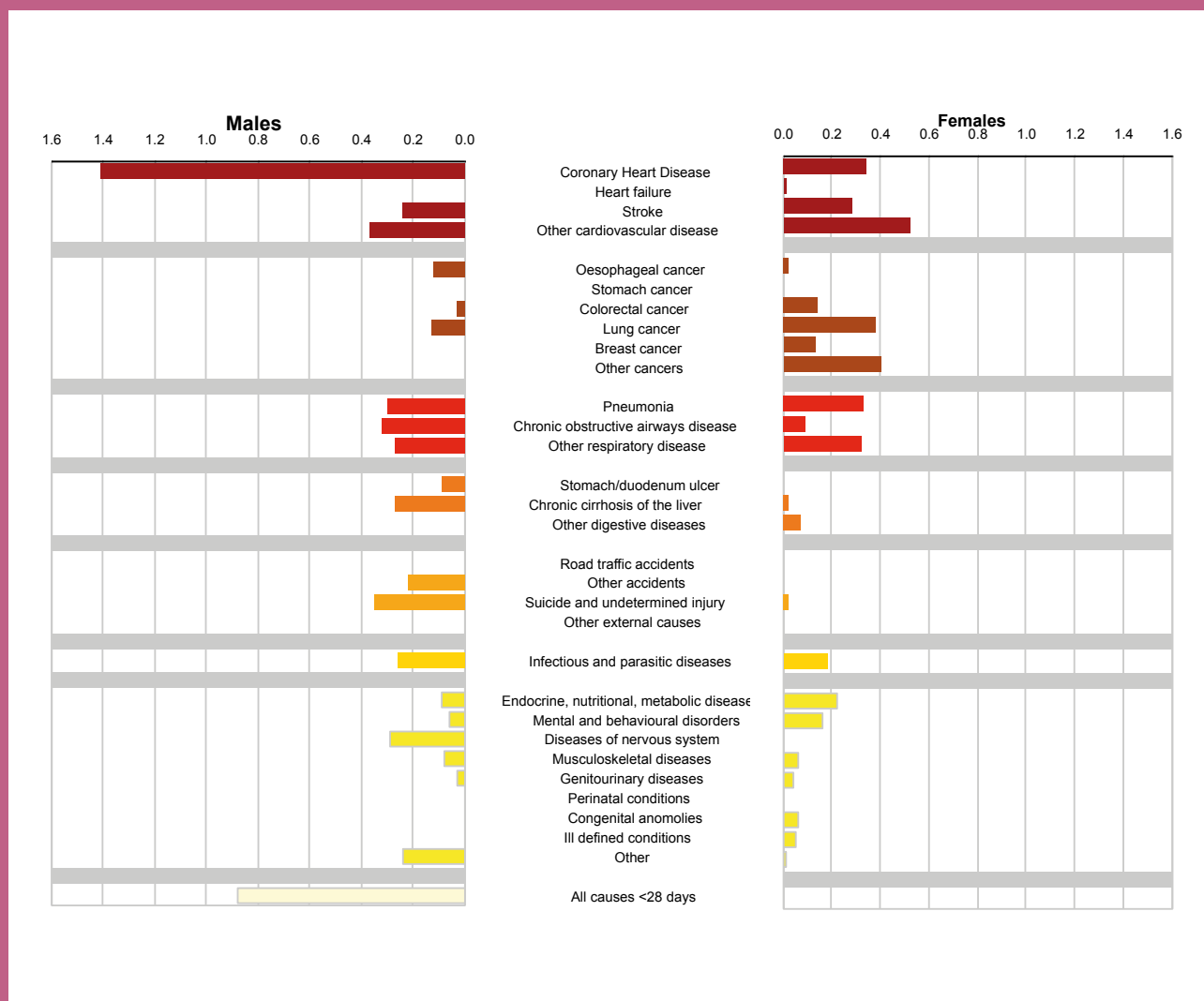


Source: London Health Observatory

The gap in life expectancy in 2001–2005 between the most and least income deprived in Lewes was 3.5 years in males and 3.9 years in females. The largest contributor to the life expectancy gap in males in Lewes is circulatory diseases (29%), followed by cancers and digestive diseases (both 20%). Circulatory diseases are also the largest contributor to the female life expectancy gap (33%), followed by respiratory conditions (18%). Please see figure 37 in the online report.

Further analysis of the gap in life expectancy during 2001–2005 shows that in both males and females, the largest years of life that could be gained if those in the most deprived areas experienced the same mortality as those in the least, is in mortality from CHD (0.76 and 0.80 years respectively). In males ‘other digestive’ diseases has the next largest possible gain (0.46 years), and in females COPD (0.53 years) and suicide (0.50 years). See Figure 38.

Figure 40: Possible gain in life expectancy in Rother (in years)

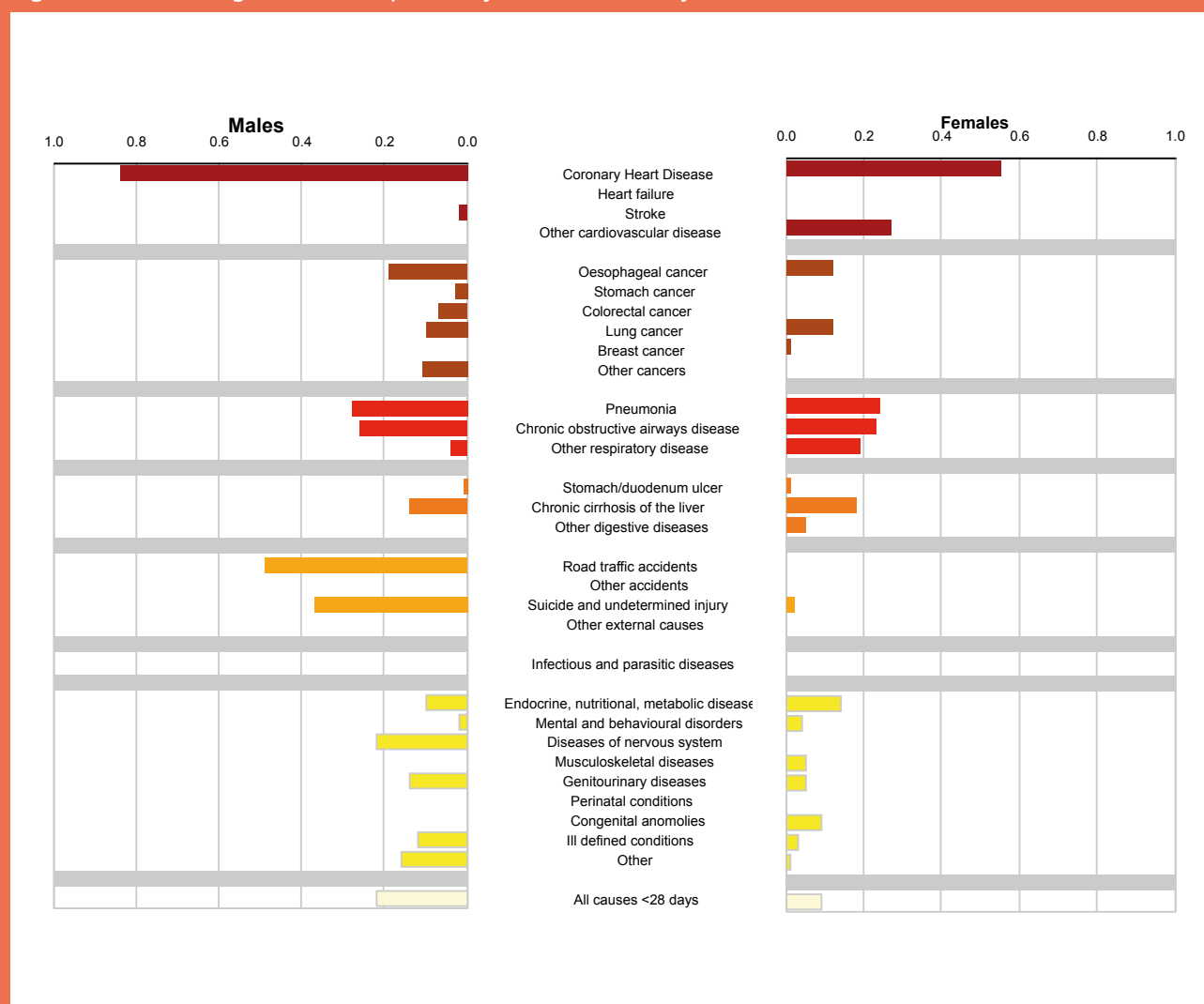


Source: London Health Observatory

For 2001–2005 there is a gap in life expectancy between the most and least income deprived in Rother of 5.3 years in males and 1.9 years in females. Circulatory diseases are the largest contributor to the gap in life expectancy in males in Rother (33%), as well as in females (30%). Cancers only make up 5% of the gap in males but 28% of the gap in females. Please see figure 39 in the online report.

Breaking down the gap in life expectancy further shows that if males from the most deprived areas in Rother experienced the same mortality rates for CHD, and deaths within 28 days of birth, there could be a gain in life expectancy of 1.41 and 0.88 years respectively (note that the data on deaths within 28 days of birth will be based on very small numbers). In females, the largest potential gain is for 'other cardiovascular diseases' (excluding CHD, heart failure or stroke) where there could be a gain of 0.52 years, see Figure 40.

Figure 42: Possible gain in life expectancy in Wealden (in years)



Source: London Health Observatory

The gap in life expectancy in 2001–2005 between the most and least income deprived in Wealden was 2.3 years in males and 2.2 years in females. External causes of death and circulatory diseases are the highest contributors to the gap in life expectancy in males in Wealden (both 22%) in 2001–2005. In females the main contributors to the gap are circulatory diseases (30%) and cancers (28%). Please see figure 41 in the online report.

Further analysis of the breakdown of the gap in life expectancy shows that in males from the most deprived areas, the largest potential gains in life expectancy are from CHD (0.84 years) and road traffic accidents (0.49 years) (Figure 42). In females, if those experienced the same mortality from CHD in the most deprived areas as in the least, there could be a gain in life expectancy of 0.55 years.

Joint Strategic Needs Assessment

Work on agreeing an approach and putting in place a Joint Strategic Needs Assessment (JSNA) programme commenced in August 2007. To date the JSNA programme comprises three distinct parts: JSNA indicator scorecards; comprehensive needs assessments; focused work on increasing life expectancy.

1. JSNA Indicator Scorecards

During August and early September 2007, local indicator scorecards were developed which were based initially upon the description of the types of minimum sets of data and analyses that PCTs and Local Authorities should carry out, as outlined in the Commissioning Framework for Health & Wellbeing, March 2007. As part of this work, the Doncaster Model (a Quality and Outcomes Framework (QOF) Benchmarking Tool developed by Doncaster PCT) was used to investigate predicted versus known prevalence for QOF indicators. An additional local development was the incorporation of as much data as possible at two different geographical levels of aggregation, a Local Authority Hierarchy (ie. ward, district/borough, county level data) and a PCT Hierarchy (ie. GP practice, practice based commissioning cluster, PCT level data). As a result of this, Local Authority and PCT Hierarchy Reports were produced comprising of 143 scorecards. They were widely disseminated and included on both PCT websites (www.esdw.nhs.uk) and (www.hastingsandrother.nhs.uk) and have also been included on East Sussex in Figures, a data observatory developed by East Sussex County Council (www.eastsussexinfofigures.org.uk).

In December 2007, the Department of Health published Guidance on Joint Strategic Needs Assessment which aimed to support the successful discharge of the new JSNA requirement by providing additional practical advice. In particular, it addressed a major criticism of the original guidance that focused on the very limited consideration given to children within the guidance. As a result of this new guidance, additional scorecard work was undertaken to produce a Children's Supplement which presented 78 scorecards relating specifically to children's health and children's services. The Children's Supplement was published in June 2008.

In April 2009, an update on some of the initial scorecards work was published together with some new scorecards. In total it contained 99 scorecards.

In December 2009, the first of what is to become an annual revision of all the JSNA scorecards was published. This comprises a total of 289 scorecards presented under the following headings:

- Demography
- Social / environmental context
- Lifestyles and risk factors
- Burden of ill-health
- Burden of ill-health – mortality
- Burden of ill-health – primary care
- Burden of ill-health – hospital care
- Services – social care
- Services – health
- Services – children's services
- User perspectives on services

2. Comprehensive Needs Assessments

As part of the JSNA approach and to complement and enhance the scorecards, specific comprehensive needs assessments have been undertaken to support the development of joint commissioning strategies and other plans. These include to date:

- Older people
- Children
- Learning disabilities
- Adult mental health
- Adult physical and sensory disability
- Oral health
- Sexual health
- Lewes Prison
- Offender health
- Alcohol misuse
- Children with chronic and complex health needs
- Black and minority ethnic groups (including gypsies and travellers)

All the comprehensive needs assessments are available on the PCT websites. They have informed our joint commissioning of services for East Sussex residents and sections of this report.

3. Focused Work on Increasing Life Expectancy

In East Sussex we've done some specific inequalities work focusing on the twenty wards with the lowest life expectancy across East Sussex, (compared to the rest of the wards in East Sussex), which is aimed at improving life expectancy and reducing the gap in life expectancy.

This has involved increased effort on getting people to stop smoking and increasing prescribing of cholesterol lowering drugs. This programme of work is called Investing in Life and to date the gap has reduced the life expectancy gap from 4 years to 3.5 years between the 20 targeted wards and the rest of East Sussex.

Recommendations

1. The Joint Strategic Needs Assessment programme should be maintained and developed further to ensure a shared evidence base, to support commissioning, to improve health and wellbeing outcomes and reduce inequalities.

How are we tackling Health Inequalities?

The background of the slide features a light blue upper section and a green lower section. A diagonal line separates the two colors. A lighter green, semi-transparent triangular shape is positioned in the middle, pointing towards the top right corner.

Promoting Healthy Lifestyles

Increasingly the diseases people experience are linked to lifestyle choices such as smoking, exercise, diet and drinking alcohol. However the choices people make are influenced by their circumstances, and money, education and environmental factors play a major part. All partners across East Sussex have an important role in supporting people to make healthy choices, and removing the barriers which prevent people from leading healthy lifestyles. The main aims of health improvement and health promotion are to improve health and reduce health inequalities through preventing ill health, protecting good health and promoting better health.

There are five key areas which we look at where lifestyle changes would make a difference to health and contribute to tackling health inequalities.

These are:

- sexual health
- mental health
- tobacco control
- diet and physical activity
- alcohol

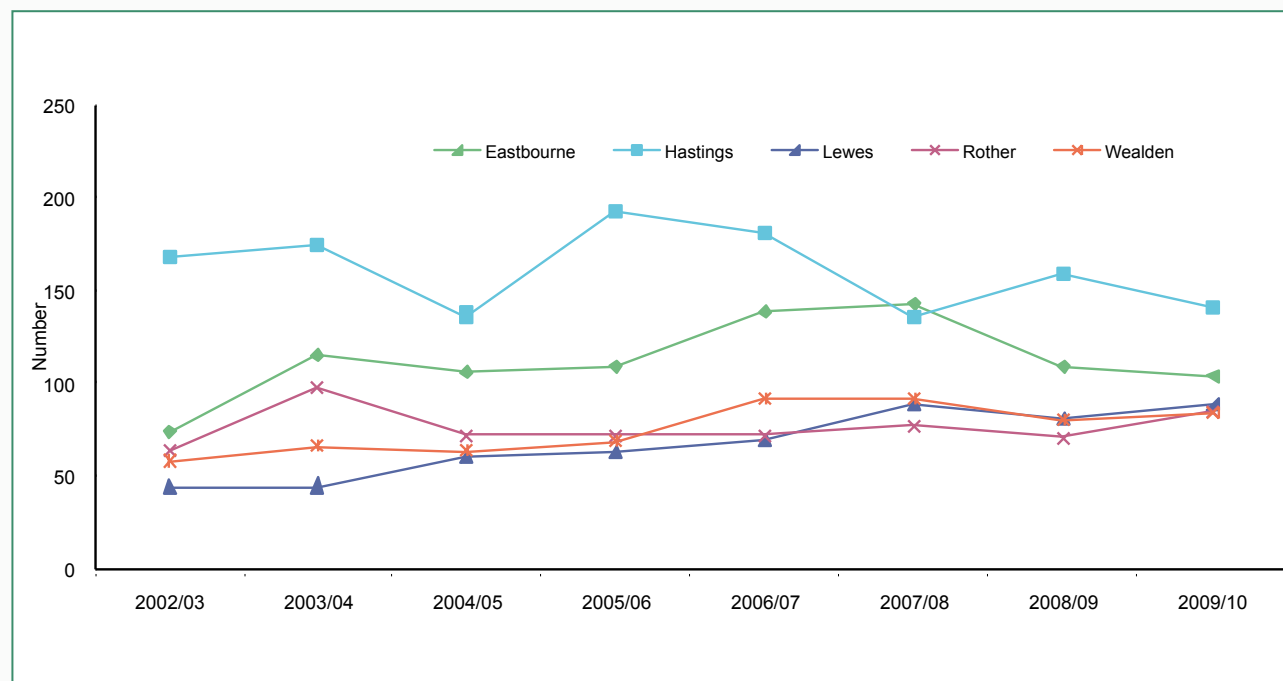
We've developed local action plans on each of these areas, and these are used to plan services that support East Sussex residents to make healthy lifestyle choices.

Promoting healthy lifestyles next steps:

1. Review health improvement strategies and action plans to ensure that these incorporate the findings of this report, recent needs assessments and new policy guidance.
2. Review commissioning for health improvement to ensure that interventions are evidence-based, cost effective and address the needs of the most vulnerable first and that there is improved access to health improvement services especially in deprived areas.
3. Identify the health promotion training and support needs of frontline workers, and commission training to address these.
4. Commission specialised health improvement services, support and workforce in line with the competencies set out in the Public Health Skills and Career Framework.

Alcohol

Figure 48: Number of directly attributable hospital admissions, East Sussex districts and boroughs, 2002/03–2009/10



Source: SUS hospital episode extracts

Why is it important?

Nationally, the vast majority of people enjoy alcohol without causing harm to themselves or to others. However, harmful drinking affects not just people's health but the economy as a whole. The harm to the individual from drinking excessive alcohol can be short or long term. There are 46 medical conditions that are caused or strongly associated with alcohol consumption. These include alcoholic liver disease, alcohol poisoning, stroke, heart disease, cancers and behavioural disorders.

In addition to its impact on health care services, alcohol related harm impacts on agencies, communities, families and individuals across East Sussex.

What is the problem in East Sussex?

The cost to the health service alone of alcohol related harm in East Sussex is estimated to be approximately £14 million per annum. East Sussex is part of a region which, despite having lower levels of increasing risk and higher risk drinking has significant numbers of dependent drinkers. Parts of the county have problem drinking patterns that are among the highest in the country.

Whilst the county as a whole appears to be close to national averages, there are distinct differences between local authority areas at district, borough and ward level.

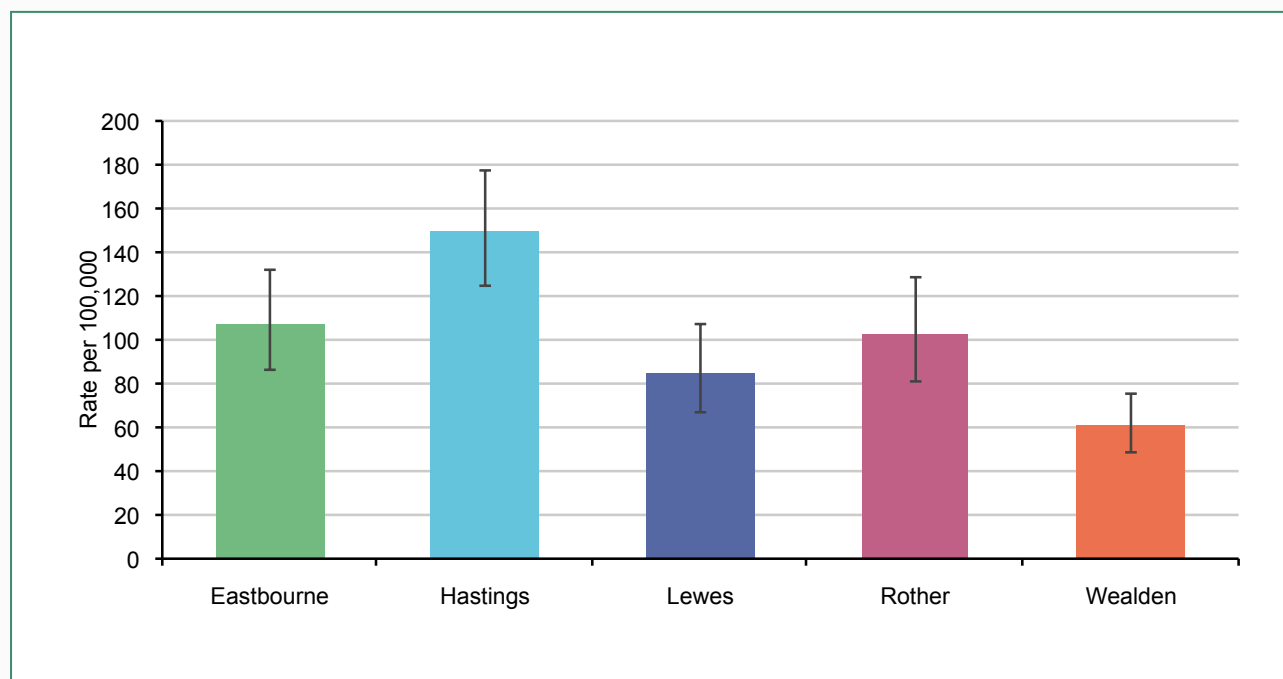
Alcohol issues are particularly marked in Hastings and Eastbourne which have some of the highest rankings in the country for a number of alcohol related indicators. Eastbourne ranks third highest area nationally for alcohol associated months of life lost. Hastings ranks 9th highest nationally for alcohol related hospital admissions for men.

Are there any specific groups affected?

The proportion of young people drinking has declined in recent years, but those who do drink are consuming more alcohol more often. Alcohol lowers inhibitions and excessive alcohol consumption is associated with a range of high-risk behaviours, including unprotected sex and offending.

Figure 49 shows that the rate of hospital admissions due to alcohol in people under 18 years of age is highest in Hastings borough, compared to the rest of the county.

Figure 49: Hospital admissions due to alcohol-specific conditions for persons aged under 18 years with 95% confidence intervals, 2005/06–2007/08 (rate per 100,000 population)



Source: North West Public Health Observatory

Rates of alcohol use are strongly linked to levels of deprivation and this is reflected in Figure 14. It is worrying that the alcohol consumption habits of young people appears to be leading to the need for hospital care and this is especially so in Hastings, which has the highest rate.

How are we tackling it?

In East Sussex there is a strategy⁴ that sets out the PCTs and partners approach to improving health through tackling alcohol, with an action plan on how to achieve this. The two key areas of the action plan focus on:

1. Support early identification of people who may be developing alcohol problems through developing and implementing evidence based 'brief interventions' training across a variety of settings including primary care, accident and emergency and other hospital specialities, including maxillofacial.

If consistently implemented across the UK, simple alcohol advice would result in 250,000 men and 67,500 women reducing their drinking levels from harmful and hazardous to lower risk each year.⁵

2. Promote 'safer levels of drinking' and self help through the use of local evidence based social marketing campaigns using a mix of nationally developed campaign materials and messages on the hidden effects of alcohol alongside locally produced materials promoting local services. This work encourages sensible drinking aimed at preventing the harms of alcohol consumption.⁶

For men who regularly drink more than 8 units of alcohol a day and women who regularly drink more than 6 units a day, the risks of various diseases, such as liver disease or stroke are significantly higher.

The East Sussex Safer Communities Partnership brings together local organisations to develop and deliver key interventions to reduce the number of increasing risk and higher risk drinkers across the county. For example the partnership are ensuring that training is available to support professionals across all agencies to be able to give up-to-date information and advice on alcohol, and that partners work together to ensure that messages about alcohol are clear and consistent.

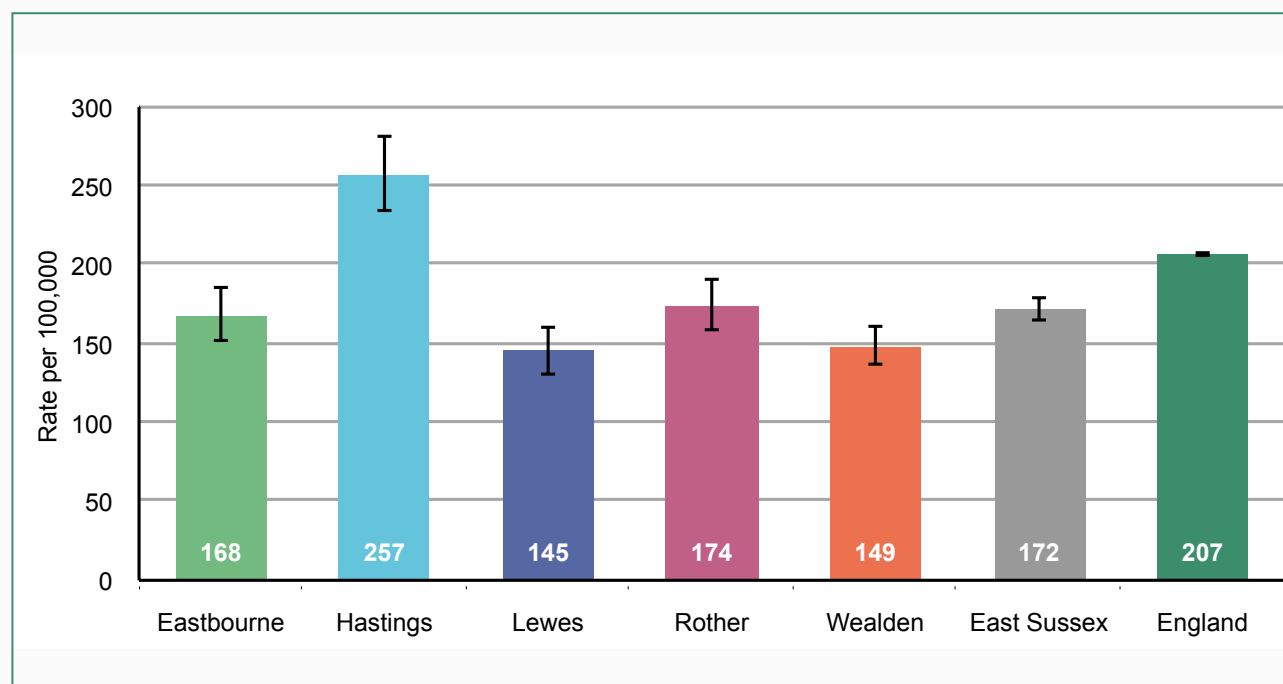
⁴ Have Fun. Stay Safe: East Sussex alcohol harm reduction strategy: 2009–12.

⁵ Safe. Sensible. Social: the next steps in the national alcohol strategy. Department of Health, August 2007.

⁶ <http://www.drinking.nhs.uk/>

Smoking and Tobacco Control

Figure 50: Deaths from smoking for people aged 35 years and over with 95% confidence intervals, East Sussex districts and boroughs, 2006–2008 (rate per 100,000 population)



Source: APHO Health Profiles

Why is it important?

Smoking is one of the most significant factors underlying the differences to be found in the health and life expectancy of the wealthiest and the poorest in our society⁷. Half of all smokers will die from a smoking related disease.

Within East Sussex, reducing smoking prevalence is key to reducing the gap in life expectancy between our most disadvantaged and the rest of our population. On average a lifelong smoker loses around 10 years of life expectancy.

What is the problem in East Sussex?

The numbers of people who smoke across East Sussex varies between wards, and is strongly linked to deprivation. Nationally, smoking prevalence in the highest income quintile is almost half that of smoking prevalence in the lowest income quintile. Across East Sussex around 23.6% of adults are estimated to be smokers.

However, there is significant variation between local authority areas, with Hastings and St Leonards estimated prevalence significantly higher at around 32%, and Wealden much lower than the average at around 19%. At ward level, differences become even more marked with three wards across the county having a prevalence of over 40%. There is a strong correlation between wards with higher rates of smoking and those with lowest life expectancy.

Figure 50 shows the death rate from smoking for people aged over 35 years. This shows that whilst East Sussex has a lower death rate than England, Hastings has a higher rate.

Are there any specific groups affected?

Smoking is a complex behaviour and the factors which influence smoking are multi faceted.

⁷ *A Smoke free Future, A comprehensive Tobacco Control Strategy for England.*
Department of Health, February 2010.

How are we tackling it?

The PCTs, district and borough councils and East Sussex County Council work together to improve the health of the population through reducing smoking prevalence. This aim is delivered through an LAA target and through LSPs that facilitate the multi-agency delivery of these targets. There is a particular focus on the 20 wards with the lowest life expectancy as part of the Investing in Life programme (see Chapter 2).

Activity to reduce the numbers of people who smoke in East Sussex is focused in three key areas:

1. **Stopping the inflow of young people recruited as smokers**

- The PCTs, East Sussex County Council and other partners work together to reduce the number of young people taking up smoking. This includes the targeting of young people within school, further/higher education and other youth settings, through the provision of brief and intermediate level training, to ensure that appropriate staff are equipped with the skills to engage with young people about smoking.

2. **Motivating and assisting every smoker to quit**

- Stop smoking services are available across the county including 1:1s from specialist services or GPs and pharmacists, or group support. We also offer additional services targeting the 20 wards across East Sussex with the lowest life expectancy (Investing in Life priority wards).
- Targeted social marketing approaches to encourage smokers to think about their smoking behaviour and to increase the numbers who want to quit.
- Training key staff to enable them to have a conversation with smokers about the health risks of smoking, motivate them to considering stopping smoking, and refer people into stop smoking services.
- Building on a pilot 'Stop before your Op' campaign the PCT has worked with its major provider of acute healthcare services, East Sussex Hospitals Trust (ESHT), to encourage smokers to be referred to stop smoking services before they have operations at the local hospitals.

- Through specific work with groups such as pregnant women and people in manual social groups.

3. **Protecting families and communities from tobacco related harm**

- Increasing the level of awareness of the harms of second-hand smoke, particularly to children, we aim to encourage people to voluntarily make their homes and private cars completely smoke free.
- Hastings Borough Council is piloting a scheme for smokers who are issued a fixed penalty notice for smoking in a smoke free setting. They are offered attendance at an NHS Stop Smoking Service as an alternative to paying the fixed penalty. In addition, the PCTs commissioned a Smoke Free Homes and Cars campaign for May and June 2010 to enforce the message around passive smoking and the dangers to children and young people associated with this.

We've also recently had a visit from the Department of Health's National Support Team (NST) for Tobacco Control, to support all partners and offer the benefit of their knowledge and experience to inform future development of tobacco control and smoking cessation work across the County. The NST identified the following five main recommendations on how partners in East Sussex could further enhance work in this area and these will be included in our next set of action plans.

1. Identify aspirations for the population that will drive down smoking prevalence using the full range of tobacco control measures.
2. Develop a co-ordinated approach to tobacco control planning across East Sussex to meet local need; informed by the evidence base, shared data and intelligence.
3. Identify clear roles and performance indicators for Tobacco Control that are regularly monitored e.g. through the LSP.
4. Develop a co-ordinated approach to communications to ensure consistency of messaging and branding across all organisations.
5. Develop of an integrated framework for stop smoking provision which is agreed by both commissioners and providers.

Obesity

Table 19: *Estimated prevalence of obesity for adults aged 16 years and over, 2003–2005*

Area	Count	%
East Sussex	98,932	22.2
Eastbourne	18,405	21.6
Hastings	18,083	24.2
Lewes	17,983	21.9
Rother	16,608	21.4
Wealden	26,265	20.9

Source: Information Centre

Why is it important?

The adoption and maintenance of healthy weight is key to reducing health inequalities and reducing the gap in life expectancy.

Obesity is linked to a large number of health problems, including an increased risk of developing Type 2 diabetes, hypertension, cancer, heart disease, and liver disease. The risk of developing chronic illness and the likelihood of premature mortality increases with the Body Mass Index (BMI) of an individual.⁸ This in turn leads to huge costs to the NHS, as a direct result of treating these diseases, and also the wider economy through lost working days.

Obesity is a significant health concern and priority nationally. In England, 66% of men and 57% of women are overweight or obese, and almost one quarter of adults (24% of men and 25% of women) are obese. Prevalence of overweight and obesity is lowest in the 16–24 age range and generally higher in the older age groups among both men and women.⁹

Obesity tends to disproportionately affect lower socioeconomic groups and the prevalence in social class V is double that in social class I. This effect is particularly noticeable in women.

What is the problem in East Sussex?

Modelled data from the Health Survey for England indicates that obesity levels in Hastings are significantly higher than elsewhere in East Sussex.

The proportion of people in East Sussex with a BMI over 30 is 22.2%, which is broadly consistent with the South East regional average of 22.3% and the national mid point average of 23.6%.

Both nationally and locally obesity is predicted to increase. Projections for East Sussex suggest that by 2015 around two fifths of the adult population will be obese if recent trends continue.

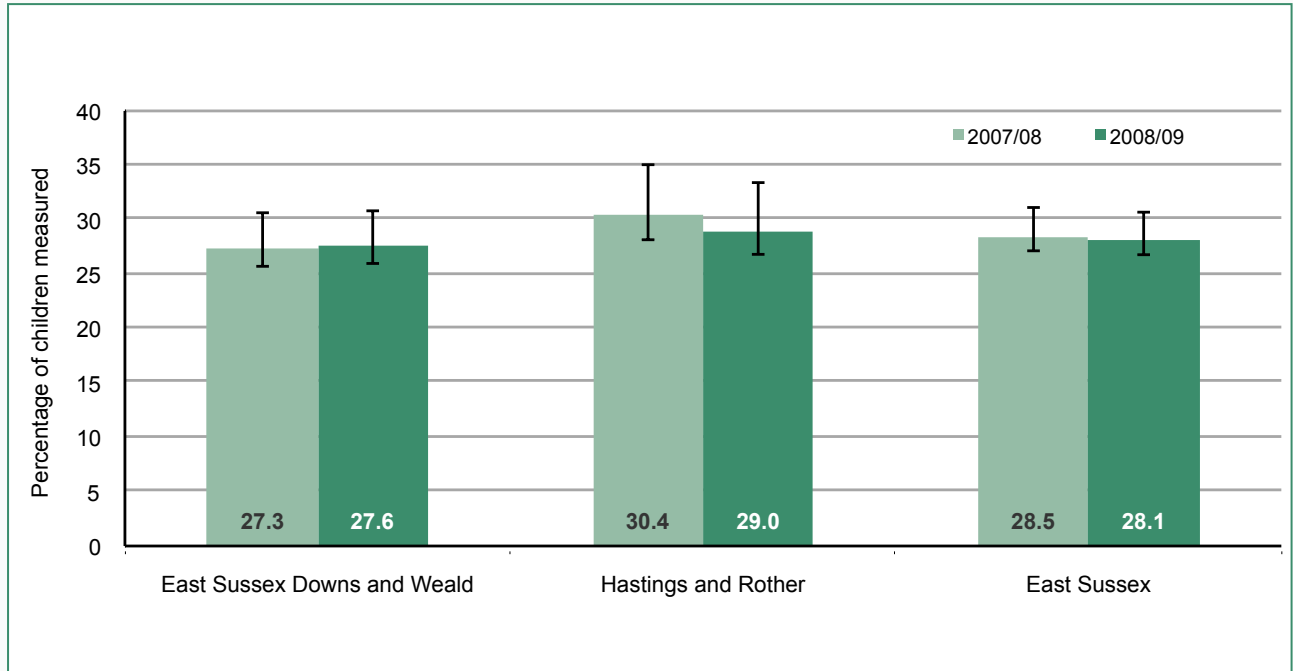
Are there any specific groups affected?

Figure 55 shows that children in Year 6 at school are not experiencing the same increase between 2007/08 and 2008/09. However, the percentage of the Year 6 population who fall into the overweight or obese category (28.1%) is higher than the Reception Year (20.9%).

⁸ *Healthy Weight, Healthy Lives: a cross-government strategy for England*. HM Government, 2008.

⁹ *Lightening The Load – Tackling Overweight and Obesity*. National Heart Forum, 2007.

Figure 55: *Percentage of children in Year 6 overweight or obese with 95% confidence intervals, East Sussex PCTs, 2007/08 and 2008/09*



Source: National Child Measurement Programme

How are we tackling it?

The local approach to tackling overweight and obesity is set out in the NHS East Sussex Downs and Weald and NHS Hastings and Rother Choosing Health Obesity Strategies and accompanying Action Plans. These strategies are delivered through the district and borough Health Improvement Partnerships (HIMP). To address inequalities in health, initiatives are focused in particular on the 20 wards with the lowest life expectancy, where improving diet and increasing participation in physical activity can have a significant impact.

'Healthy Weight, Healthy Lives'⁸ and its accompanying implementation framework set out the key themes and areas for action in tackling obesity. These are:

1. Children: healthy growth and healthy weight
2. Promoting healthier food choices
3. Building physical activity into our lives
4. Creating incentives for better health
5. Personalised support for overweight and obese individuals

The PCTs and partners work together to deliver a range of targeted programmes to increase physical activity participation, promote a healthy diet and raise awareness of the importance of adopting and maintaining a healthy weight. These include:

1. **Local grass roots based physical activity promotion projects:**
 - Active Hastings
 - Active Rother
2. **Targeted recommendation to exercise:**
 - GP Exercise Referral (Hastings and Rother)
3. **Community based initiatives to improve nutrition:**
 - Community Fruit and Vegetable Project
 - Food In Schools Programme
4. **Targeted support to change health related behaviour:**
 - Health Trainers
 - Lifestyle Facilitation Service

Sexual Health

Why is it important?

Poor sexual health can have a long lasting impact on people's lives because of significant health consequences such as pelvic inflammatory disease, ectopic pregnancies/infertility, HIV, cervical and other cancers, Hepatitis, chronic liver disease and liver cancer, recurrent herpes and premature delivery.

There is a clear relationship between sexual ill health, poverty and social exclusion. Evidence suggests that significant inequalities in health status are associated with a variety of factors, including ethnicity, geography, sexual orientation and age.¹⁰

Teenage pregnancy is associated with a number of negative health and social consequences, for both mother and child. These include problems associated with low birth weight, higher infant mortality rates, lower levels of breast feeding and higher levels of mental health difficulties for teenage mothers. Teenage parents also tend to experience more socioeconomic deprivation and lower levels of educational attainment. In turn, these factors are inherited by the children of teenage parents.¹¹

Genital Chlamydia infection is the most commonly diagnosed bacterial sexually transmitted infection (STI) in England. Prevalence of the infection is highest in sexually active young men and women under the age of 25 years. Untreated infection can have serious long-term consequences. In women, it can lead to pelvic inflammatory disease, ectopic pregnancy and tubal infertility. In men, it can lead to epididymitis and epididymo-orchitis.

In both men and women, it can lead to Reiter's Syndrome. The infection often has no symptoms but is easy to treat when diagnosed. Treatment and partner notification can reduce complications that are estimated to cost the NHS millions of pounds per year.

What is the problem in East Sussex?

There is significant variation in under-18 conception rates within the county, with teenage conception rates in Hastings being consistently higher and rates in Wealden being consistently lower than the East Sussex average. The overall East Sussex reduction for 2008 was a 1.5% reduction from the baseline, with the county rate at 39.2 per 1,000 females aged 15–17 years old.

In 2009/10, coverage for Chlamydia screening in East Sussex was much higher than the South East average and slightly higher than the England average, at around 24% of the eligible East Sussex population. However, fewer people tested positive for Chlamydia in East Sussex than on average across the South East, or England as a whole. It is not clear whether this is due to lower infection rates in East Sussex or due to screening services not reaching those most at risk.

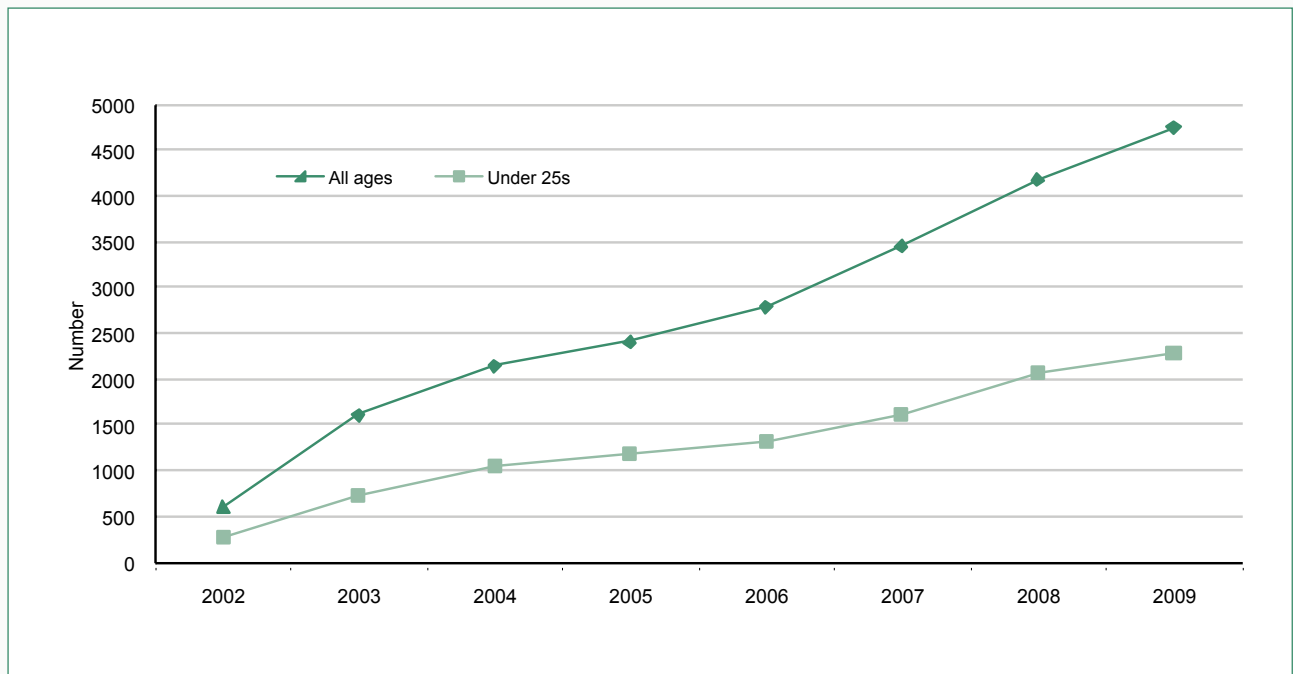
The number of people having screens for sexually transmitted infections has increased in recent years; however, the rate of increase is less marked for younger people. It is important to note that these data are based on people using East Sussex clinics, so this may reflect increased availability of services locally rather than increased numbers of the East Sussex population being screened (i.e. more people in previous years may have travelled out of area for their screens). In addition, young people may also be accessing sexual health screening through other specialist services e.g. Further Education nurses.

Figure 59 shows the number of HIV antibody tests performed at East Sussex clinics. This too shows an increase in the number of people being screened but a less marked increase for younger people.

¹⁰ *Performing Better? A focus on sexual health services in England*. London: Commission for Healthcare Audit and Inspection, 2007.

¹¹ Tripp and Viner. *Sexual health, contraception and teenage pregnancy*. British Medical Journal, 330: 590–93, 2005.

Figure 59: Number of sexual health screens / HIV antibody tests at East Sussex genito-urinary medicine clinics, 2002–2009



Source: East Sussex GU clinics

Are there any specific groups affected?

We know that certain groups of young people are at higher risk of becoming teenage parents. Rates of teenage pregnancy are strongly linked to the aspirations that young people have. There is an inverse relationship between GCSE attainment in school and rates of teenage pregnancy. Where GCSE attainment is low, teenage pregnancy rates are high. Groups at increased risk of becoming a teenage parent include: those with low educational achievement; those not in education, employment or training (NEET); children and young people who are looked after either in care or a foster placement; those who misuse alcohol and/or drugs; those in contact with Youth Offending services; and those whose mothers were teenage parents.

How are we tackling it?

The East Sussex Teenage Pregnancy Strategy places a focus on tackling both the causes and consequences of teenage pregnancy, and sets out proposals to improve the quality of integrated services, making them more flexible to meet the needs of young people. It emphasises improving access to sexual health services, through providing services at times which fit with young people's lives. Work is underway to implement the nationally recognised "You're Welcome" quality criteria, which sets out principles that assist health services (including non-NHS provision) to become young people friendly and the targeting of evidence-based early interventions that have been shown to be effective at delaying or reducing early sex to vulnerable population groups such as Looked After Children. (See Children's section for more detail).

In 2009/10 coverage for Chlamydia screening in East Sussex was much higher than the South East average and slightly higher than the England average, at around 24% of the eligible East Sussex population.

Mental Health and Wellbeing

Why is it important?

Mental health promotion can be defined as any action to enhance the mental wellbeing of individuals, families, organisations and communities.

Wellbeing is distinct from mental illness. Someone can have symptoms of a mental illness and still experience wellbeing, just as a person with a physical illness or long-term disability can. In the same way, someone can have poor mental wellbeing, but have no clinically identifiable mental illness.

The King's Fund has predicted that costs to the NHS and social care associated with poor mental health will double between 2007 to 2026. Improving mental health brings benefits to individuals and society. There is a clear association between good mental health and better outcomes across a number of domains: years of life, physical health, educational achievement, avoiding criminality, maintaining a home and employment status. A small change in the average level of wellbeing across the population would produce a large decrease in the percentage of people with a mental disorder.

Mental health problems are linked to poor diet, less exercise, heavy smoking and drug and alcohol misuse. Depression at age 65 is linked to a 70% increased risk of dying early. People diagnosed with mental health problems are more likely to have risky lifestyles e.g. smoking, drinking or drug use – and are less likely to achieve the recommended intake of fruit and vegetables or participation in exercise.

What is the problem in East Sussex?

Mental health problems are extremely common: one in six adults will have a mental health problem at any one time, and for half of these people the problem will last longer than a year. Over half of all adults with mental health problems will have begun to develop them by the time they were 14. For some people, mental health problems last for many years, particularly if inadequately treated. The following figures illustrate how common mental health problems are:

- 10% of children have a mental health problem and many continue to have mental health problems into adulthood.
- 10% of new mothers suffer from post-natal depression.
- 19% of women and 13.5% of men are affected by depression or anxiety at any one time.
- Half of all women and a quarter of men will be affected by depression at some time in their life and 15% experience a disabling depression.
- 4% of the population has a personality disorder.
- 1% of the population have a serious mental health problem.

Are there any specific groups affected?

Life course events are associated with increased risk of mental health problems – e.g. economically inactive people have up to a 5.5-times greater risk of mental health problems, those living in a fuel poverty or in debt are up to four times more likely to experience mental health problems, and depression increases four-fold in those who experience flooding.

How are we tackling it?

The East Sussex PCTs, Improving Mental Wellbeing Strategy 2009–2012 sets out the priorities for local action.

During 2009/10, Mental Health Promotion Specialists have worked closely with colleagues in both the NHS and a wide range of partner organisations to deliver a variety of interventions to support the strategy's implementation.

The strategy aims to support and strengthen individuals and communities and reduce the structural barriers to mental wellbeing by:

- addressing stigma and discrimination
- increasing awareness and reducing inequalities.

This is underpinned by the following three levels of mental health promotion:

1. **Strengthening individuals (personal)**, increasing emotional resilience through interventions designed to promote self-esteem and life coping skills e.g. communicating, negotiating relationships and parenting skills.
2. **Strengthening communities (social)**, which involves increasing social inclusion and participation, improving neighbourhoods, environments, developing the areas of health and social services that support mental health, implementing anti-bullying strategies in schools, improving workplace health, community safety, childcare and self-help networks.
3. **Reducing structural barriers to mental health (structural)** through initiatives to reduce discrimination and inequalities and to promote access to education, meaningful employment, housing, services and support for those who are vulnerable.

Mental Health Awareness Campaign

A series of innovative resources have been developed to promote the importance of good well-being, provide tips for self care and contact details of local and national support organisations. These include:

- a booklet produced in collaboration with partners entitled: '*Taking care of your top two inches: a guide to wellbeing*'. This has been distributed widely across the county and an adapted version was produced in collaboration with HMP Lewes for use within the prison and other offender management settings.
- a '*Mind your Head: how well do you score*' scratch card to encourage people to assess their own mental health which provides 12 recognised self help steps. Users are then referred to the local website www.mytoptwoinches.com for further information.
- the re-launch of the FMH website¹², which has been designed especially for young men aged 16–25 years with information and advice and sources of support.
- development and distribution of resource packs to a range of organisations such as GP practices and workplaces.
- a 'Books can help' scheme in collaboration with East Sussex County Council Library Services and Sussex Partnership NHS Foundation Trust to promote reading, the availability of self help books and other resources from local libraries.

¹² www.fmhsussex.co.uk

The Top 3 Causes of the Life Expectancy Gap: Circulatory Diseases, Cancer, Respiratory Diseases

Introduction

Circulatory diseases, cancer and respiratory diseases contribute significantly to the gap in life expectancy between the well-off and the less well-off and, in this section, we describe the work to address these diseases, focussing particularly on work within primary care services. It is important to effectively treat the symptoms of these diseases to prevent further ill health (secondary prevention). This work should run alongside other initiatives that prevent the diseases occurring, such as encouraging an increase in physical activity and identifying and treating high cholesterol (primary prevention). These initiatives can be delivered through primary health care services, as well as through the voluntary sector, council services and other routes. Primary prevention work was described earlier in this chapter.

Circulatory diseases

There are a number of different services in East Sussex that are providing care for patients with cardiac problems on a local basis to provide care closer to home. These services are designed and chosen by local GPs through Practice Based Commissioning and include:

- Instead of going to hospital for heart problems that are not emergency cases, patients now attend the Hailsham Community Cardiology Service (HCCS), (although some patients will still attend the rapid access chest pain clinic).
- In the Newhaven, Seaford and Lewes area, we are developing a consultant-led, community-based cardiac clinic, to be run from Newhaven Downs Polyclinic.
- In the Hastings and Rother area, a scheme called Hastings and Rother Treatment for Hearts (HARTH) is in place. This service ensures that patients with heart problems are all cared for using the same agreed approach to try to improve their lifestyles and prevent future problems.

Atrial fibrillation is a cardiac arrhythmia (a change from the normal heartbeat) that increases the risk of developing a stroke. Over the last year the Sussex Heart Network (SHN) have been supporting and auditing practices on how they follow new national guidance in this work. A series of recommendations have been produced by the SHN following their audit and they will be running an education programme for GPs over the coming year. Harmful alcohol use is one predisposing factor for arrhythmias and coronary heart disease generally and the work to support targeted prevention of harmful drinking, described earlier in this chapter, is essential in tackling the life-expectancy gap.

Anti-coagulation (prescribing and monitoring to prevent blood clots) is another area where services have been moved from secondary care into primary care in East Sussex, with the aim of providing more accessible services and reducing costs. New schemes are in place in the NHS Hastings and Rother, and NHS East Sussex Downs and Weald areas.

The clinics are held in GP surgeries and led by practice nurses or health care assistants supported by GPs. The GPs maintain the responsibility for any changes in medication and give advice to those patients requiring it. The use of near-patient testing techniques and computerised decision-support systems improve the efficiency, safety and quality of anticoagulation control in a primary care setting.

In secondary care services, the way in which heart attacks are dealt with when they first occur has changed recently. Ambulance services were involved in administering clot-busting drugs, but now the aim is to unblock the blood vessel in hospital as soon as possible. This procedure is known as primary angioplasty and is available at East Sussex Hospitals Trust and Brighton and Sussex University Hospitals Trust.

Identifying and controlling hypertension, high cholesterol and diabetes in primary care

The NHS health checks programme aims to help prevent heart disease, stroke, diabetes and kidney disease. It is intended that, from April 2012, everyone between the ages of 40 and 74, who has not already been diagnosed with one of these conditions, will be invited (once every five years) to have a check to assess their risk and will be given support and advice to help them reduce or manage that risk.

In East Sussex, we have commenced health checks in both 'Investing in Life' practices and other practices in 2009/10. (Investing in Life practices are those seeing residents of the 20 wards in East Sussex with the lowest life expectancy).

When high cholesterol is identified, it can be controlled by diet. Statins may also be prescribed. Last year, approximately £6 million was spent on statin prescribing in East Sussex.

Those living with long-term conditions, such as heart disease or diabetes, can be helped to maintain their own health if they attend support groups where issues such as diet and mental wellbeing are discussed. Plans to revise these self-care patient programmes are underway and developments are anticipated in 2010/11.

Cancer

East Sussex has a high incidence of cancer, which may be due to its high proportion of older residents. It also has a lower one-year survival rate for some cancers, especially lung and bowel cancer, compared to other areas of the country and other EU countries. These cancers were, on average, diagnosed at a later stage in East Sussex and especially Hastings and Rother compared to other areas of Sussex.¹³

Data shows that a higher percentage of people from areas with higher socioeconomic deprivation are diagnosed at later stage for lung and bowel cancer, compared to people from more affluent areas in East Sussex. Approximately 65% of bowel cancer patients and 60% of lung cancer patients were men.¹⁴

To improve cancer survival rates in the first year after diagnosis, and to reduce cancer health inequalities in East Sussex, we are taking part in the National Cancer Awareness and Early Diagnosis Initiative (NAEDI), funded by the Department of Health and Cancer Research UK. It aims to encourage people to seek advice earlier and reduce delays in primary care.

The NAEDI campaign has delivered outreach cancer awareness sessions for the public and health professionals. It is focused on helping men aged 45 and over to be aware of the main early symptoms of bowel, prostate and lung cancer and to visit their GP as early as possible if they are experiencing any symptoms so that the disease can be diagnosed.

These are the symptoms highlighted by the campaign:

1. Change in bowel habits for more than 6 weeks
2. Frequent visits to the toilet, especially at night
3. A persistent cough for more than 3 weeks.

Brighton and Hove Albion Football Club's community programme have supported this work. Training sessions have also been delivered to pharmacists, health trainers and homeless centre staff, and have been well received. The majority of participants stated that they are now more aware of early cancer symptoms. Most people also felt more confident talking about cancer health issues with others. Many also wanted more information about men's health issues and more cancer-awareness campaigns. GPs and practice nurses have been informed about the campaign, local cancer statistics and key messages via protected learning events, websites and mail shots.

The campaign will be evaluated later this year to inform future work to improve one-year cancer survival rates in East Sussex. The PCTs have applied for funding to carry on and extend the campaign to more areas in East Sussex in 2010/11, with a focus on raising awareness of lung and bowel cancer.

We have also applied for funding to pilot a new Cancer Risk Assessment tool in GP practices, aimed at improving existing guidelines for cancer referrals.

¹³ Thames Cancer Registry data 2007, provided by Sussex Cancer Network, 2010.

¹⁴ Thames Cancer Registry data 03/06, combined with PCT health intelligence data 2009.

Respiratory Diseases

Chronic obstructive pulmonary disease (COPD) is a respiratory disease caused by damage to the lungs over many years. The main preventable cause in East Sussex is smoking and, given the higher levels of smoking among lower income groups, the incidence of COPD is higher in these populations. Cold and damp environments, poor diet and other problems associated with low incomes and poverty will aid progression of the disease.

A local enhanced primary care service is provided to patients aged over 40 years who are smokers. These patients are screened in primary care using spirometry (a measurement of the amount of air taken into and exhaled from the lungs) both opportunistically and in defined nursing appointment times. Patients with COPD are identified through this process and can then be treated appropriately.

Access to specialist nursing and physiotherapy benefits patients with this condition. In Hastings and Rother, COPD services are integrated across community, primary and secondary care services. The aim of this service includes reducing the readmission rate for people with a diagnosis of COPD.

The incidence of pneumonia increases with age. Pneumonia rates in East Sussex are comparatively high, due to the age profile of our population. The medicines management team have been supporting GP practices in prescribing for pneumonia and work with care homes and A&E departments is aimed at keeping older people in the community where possible. Seasonal flu and pneumococcal vaccination presents an opportunity to remind older people in poverty about support available to help keep warm.

Top 3 Causes of the Life Expectancy Gap next steps:

1. It is recommended that work continues to reduce the variation in identification, treatment and support provided to patients with: hypertension, high cholesterol, atrial fibrillation, poorly controlled blood sugars and chronic obstructive pulmonary disease (COPD).
2. Staff should continue to be supported to maintain and update skills in identifying and caring for people with coronary heart disease (CHD), respiratory diseases and cancer, as well as people with risk factors for these health problems.
3. The NHS Health Checks Programme commenced in 2009/10 in parts of East Sussex and now needs to be extended.
4. Self-care patient programmes for those people living with long-term conditions should be revised and/or developed in 2010/11.
5. Further work to improve cancer survival at one year is needed, especially among lower income groups and men, and this should be informed by the evaluation of the PCTs' National Cancer Awareness and Early Diagnosis Initiative (NAEDI)-funded campaigns.

Children and Young People

The key agencies whose work affects the lives of children and young people are all members of the East Sussex Children and Young People's Trust (CYPT) partnership. The Trust partnership has drawn up an overarching plan to improve health and wellbeing outcomes for children and young people, known as the Children and Young People's Plan.

There are numerous services and work areas with the core aim of reducing inequalities in children. These are summarised below.

The Healthy Child Programme

This is the overarching framework that both provides universal health and wellbeing services for children and identifies and provides enhanced services for families and children with additional needs.

Children's Centres

Children's Centres provide a range of services to support families with children up to five years old. These include early education, health services and childcare. The core aim is to reduce health inequalities and improve health outcomes for children aged 0–5 years.

Family Nurse Partnership

The Family Nurse Partnership Programme (FNP) is based on an intensive home visiting schedule from the 16th week of pregnancy until the child is 2 years of age, with an emphasis on primary prevention, pregnancy and the first two years of life. It is aimed at women and their partners identified as requiring extra support, and generally to those up to 20 years of age in Hastings and St Leonards as a national pilot service.

Reducing teenage pregnancy

The overall East Sussex reduction for 2008 was 1.5% from baseline, with the county rate at 39.2 per 1000 females aged 15–17 years. At district and borough level, there is more variation in conception rates from year to year because of the relatively small number of teenagers who become pregnant.

There is a strong evidence-base for reducing teenage pregnancy and this is reflected both in the county level and local PCT action plans. Work to reduce the rate includes both a population approach and targeted work focusing on the geographical areas with the highest rates.

Core themes involve: developing the aspirations of young people, increasing their academic attainment, securing effective delivery of Sex and Relationship Education, and providing accessible contraception services, which are the key pillars of reducing rates of teenage pregnancy

Increasing breastfeeding

The PCTs' Breastfeeding Strategy 2009–2012 recognises that the incidence of breastfeeding is known to be strongly associated with maternal socioeconomic status and educational attainment.¹⁵ Less affluent areas tend to have lower rates of breast feeding both at initiation and in terms of how long breast feeding is continued. In addition, evidence states that, in the UK, breastfeeding rates are particularly low among disadvantaged white women, particularly teenage women, first-time mothers or lone parents.¹⁶

¹⁵ Breastfeeding Strategy 2009 – 2012. NHS East Sussex Downs and Weald and NHS Hastings and Rother, 2009.

¹⁶ Dyson, L. Renfrew M. et al. Promotion of breastfeeding initiation and duration, *Evidence into practice briefing*. London: National Institute of Health and Clinical Excellence, 2006.

Priorities for the PCTs and partners, including the third sector, to improve and support breast-feeding include:

- ensuring all expectant and new parents are fully informed when making infant feeding choices;
- supporting mothers to initiate and sustain exclusive breast feeding until their child is six months of age, by identifying problems early;
- ensuring services are multifaceted and target mothers who are less likely to breastfeed;
- encouraging professionals and community partners to work collaboratively and target support to mothers and babies in different settings; and
- listening to parents' views to shape and influence future services.

Securing good emotional and mental wellbeing

A new service is being commissioned to work with Looked After Children who are awaiting adoption, which will provide assessment and treatment for those who have emotional and wellbeing difficulties.

We are also guaranteeing training for staff working across agencies to increase their skills when providing support/advice and care to our most vulnerable young people, and a new mental health practitioner will be working to provide mental health assessments on all young care leavers, to ensure their mental health needs are identified and interventions provided early.

The primary mental health service within East Sussex is now offering a more targeted approach, working closely with Parent Support Advisors within schools. The Parent Support Advisors will be trained to help identify early emotional mental health difficulties and work in consultation with the primary mental health service. There is also a one year pilot, co-ordinated training and good mental health awareness across secondary and primary schools in Eastbourne.

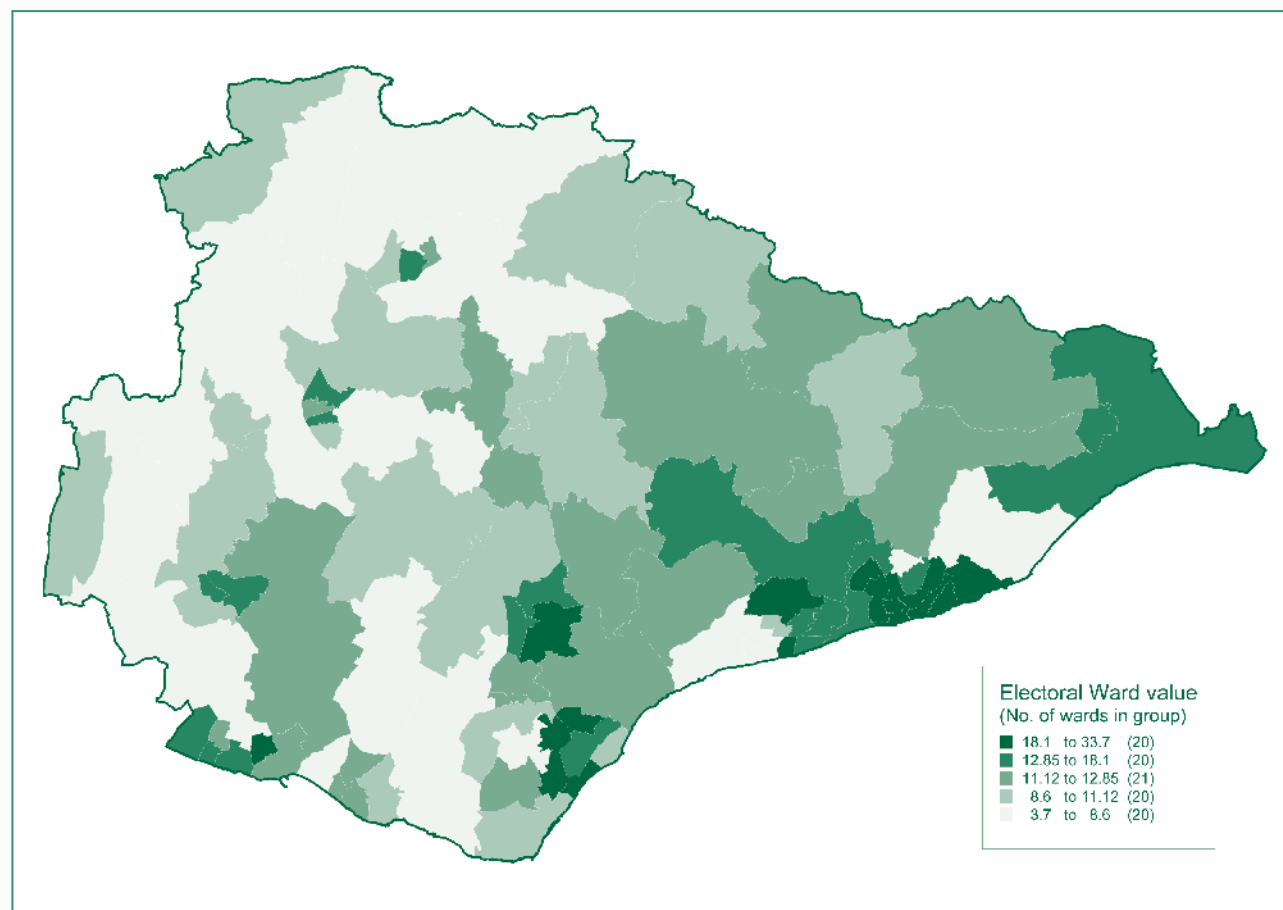
Improving communication skills and emotional and social development

There are wide differences between the skill levels of five-year olds, particularly in relation to communication skills and social and emotional development. Moreover, poor skills in these areas are strongly correlated with a range of poor outcomes later on. Addressing inequalities here is therefore crucial.

Across East Sussex, just over half (51%) of pupils achieve 5 GCSE's, including Maths and English, at grade A-C. However, there are very clearly marked differences in attainment according to deprivation, ranging from, just over one in three pupils (37%) attaining 5 GCSE's at A-C in the most deprived fifth of the county (quintile 1), compared with nearly two in three pupils (65%) in the least deprived fifth of the county (quintile 5).

A wide range of actions are currently being taken to reduce the gap in educational attainment between some children and young people and the rest in East Sussex.

Figure 67: Income Deprivation Affecting Older People Index (IDAOPI) 2007, East Sussex electoral wards



Source: Index of Multiple Deprivation 2007

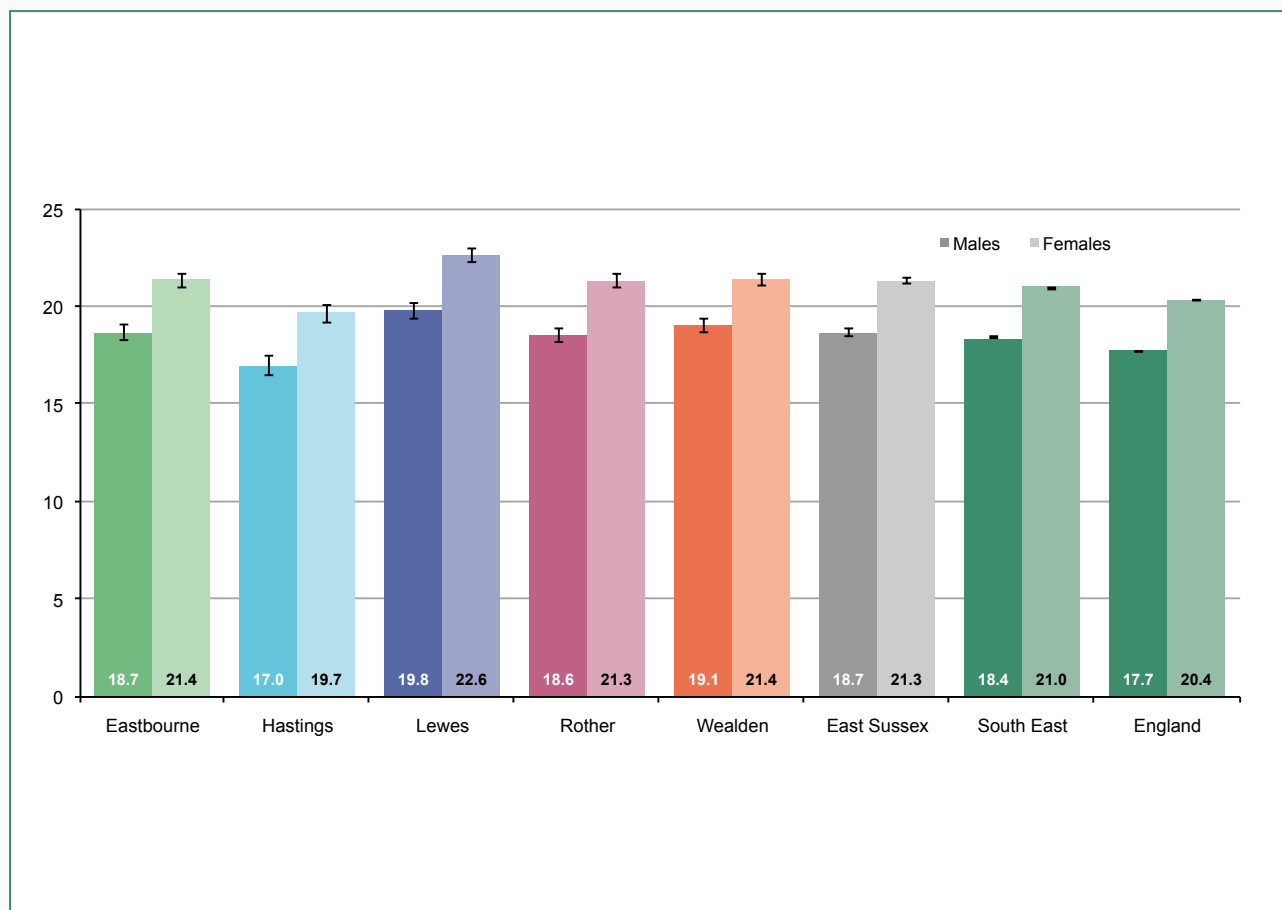
Older People

Last year's annual Public Health Report, 'The Health and Wellbeing of Older People', contained a wealth of information on the health of older people in East Sussex, which has informed the new Older Peoples Joint Commissioning Strategy 'Living Longer, Living Well' for 2011. This section presents some of the key facts.

Key facts

- The East Sussex population is older than the national profile, with almost 23% of the total population over 65 years of age. However, within East Sussex, there is wide variation. There will be a continuous increase in the number of people over 50 years old over the next five to 10 years.
- There is wide variation in the proportion of older people living in different areas and in the levels of income deprivation across East Sussex. (Figure 67)

Figure 68: Life expectancy at age 65 years with 95% confidence intervals, East Sussex districts and boroughs, 2006–2008



Source: Compendium of Clinical and Health Indicators

- In East Sussex, life expectancy at the age of 65 years is an additional 18.5 years for men and 21.1 years for women. Both sexes are living more than a year longer than the average life expectancy figure for England. However, within East Sussex, there is variation at district/borough level (Figure 68).
- Disability-free life expectancy defines healthy life as years free from limiting long-standing illness. All districts have significantly higher disability-free life expectancy at 65 years than England, except for Hastings. Disability-free life expectancy in Hastings is below the England and South East regional average but not significantly lower.
- The main causes of death in those aged 65 years or over in East Sussex reflects the national picture, with slight differences seen between men and women.
- Measures to improve health such as stopping smoking, eating a healthy diet and taking exercise, drinking alcohol in moderation, practicing safe sex, and taking part in screening programmes and vaccination programmes are key for the over 50 age group to achieve the overall benefit of adding years to life and disability-free life to years.

Living Longer, Living Well: Joint Commissioning Strategy for adults in later life and their carers 2010/15

Living Longer, Living Well is the new joint Older Peoples Commissioning Strategy.

The PCTs, East Sussex County Council, district and borough councils, and voluntary and independent sector partners have identified a joint vision and four key commissioning priorities that set the context for a range of agreed actions from 2011.

The vision

To make East Sussex a safe, healthy and enjoyable place to live for adults in later life and their carers by:

- Enabling people to live active lives with dignity and independence
- Improving quality of life and physical and mental well being
- Prioritising prevention, early detection and treatment of ill health
- Supporting them to access a range of good quality health, care and housing support services that are good value for money

Priority One

- Develop and improve the range of community services to promote independence and well being.

Priority Two

- Develop and improve accommodation options, with more community-based services and supported housing.

Priority Three

- Develop and improve the range of community services for those who have urgent, transitional or ongoing complex needs.

Priority Four

- Develop and improve the range of services for people with dementia and functional mental health issues.

It is important to note that successful health, social care and housing support outcomes for children, young people and adults achieved through effective joint commissioning and service developments are key to preventing the early deterioration of physical and mental health and wellbeing of adults and their carers in later life.

Recommendations

Promoting Healthy Lifestyles

1. Review health improvement strategies and action plans to ensure that these incorporate the findings of this report, recent needs assessments and new policy guidance.
2. Review commissioning for health improvement to ensure that interventions are evidence-based, cost effective and prioritise the needs of the most vulnerable, to reduce health inequalities, and that there is improved access to health improvement services, especially in deprived areas.

Top 3 Causes of the Life Expectancy Gap

1. It is recommended that work continues to reduce the variation in the identification, treatment and support provided to patients with: hypertension, high cholesterol, atrial fibrillation, poorly controlled blood sugars and chronic obstructive pulmonary disease (COPD).
2. The NHS Health Checks Programme commenced in 2009/10 in parts of East Sussex and now needs to be extended.
3. Further work to improve cancer survival at one year is needed, especially among lower income groups and men, and this should be informed by the evaluation of the PCTs' National Cancer Awareness and Early Diagnosis Initiative (NAEDI) funded campaigns.

Children and Young People

1. Ensure that tackling inequalities is a core theme within the Children and Young People's Plan, the overarching plan to improve health and wellbeing outcomes for children and young people.

Older People

1. The Joint Commissioning Strategy, 'Living Longer, Living Well' is designed to meet both existing and future health, social care and housing support needs for adults in later life and their carers. The lead commissioning agencies for this strategy, East Sussex County Council's Adult Social Care Department and the PCTs, should ensure implementation.
2. The services commissioned for older people across health and social care should be balanced between locating them in areas of greatest concentration of older people and also targeting those groups of older people who are likely to be in greatest need – socially isolated, income deprived and those aged over 85 years.

How can we achieve
more and move
forward faster?

The background features a light blue upper section. Below this, there are two overlapping, abstract shapes that resemble hills or a stylized landscape. The top shape is a solid green color, and the bottom shape is a lighter, lime green color. They meet at a diagonal line that slopes downwards from left to right.

Health inequalities are longstanding, deep-seated and have proved difficult to change. This final chapter identifies actions that we can expect to make an impact in a short-timescale and those expected to make an impact in the medium-to long-term.

Health inequalities are the result of a complex and wide-ranging network of factors; those that are amenable to change can broadly be split into three groups: the lives people lead; access to services; and the wider determinants of health. To reduce inequalities action is needed across all three areas.

The Lives People Lead

There are several sections in this report on promoting healthy lifestyles. The key findings are that we must get better at promoting healthy lifestyles and commissioning more effective and targeted services to enable our residents to have healthy lifestyles if they wish.

Access to Services

This final chapter examines access to the services that are provided by general practices. In doing so, it draws on the work of the Health Inequalities National Support Team (HINST), which was set up by the Department of Health in 2007. The aim was to support local partners to reduce inequalities in health by focusing on a systematic and scaled-up approach to commissioning and delivering interventions that will make a difference to health at a population level in a short timescale if delivered at a sufficient scale. We demonstrated in Chapter 2 of the report that the main contributors to the life expectancy gap across East Sussex are circulatory diseases, cancer and respiratory diseases, so in this chapter there is also a focus on CHD, cancer and COPD.

The Wider Determinants of Health

This chapter will expand the discussion about health inequalities and the wider determinants of health and identify what the NHS and local government, with other partners, can do to reduce health inequalities.

Implementing The Health Inequalities National Support Team Evidence Base

The Health Inequalities National Support Team (HINST) has produced national guidance on improving delivery through high impact changes.

These high impact changes are based on the evidence base and built around good practice identified from the visits to local areas undertaken by the HINST. The HINST have outlined ten major lessons learned:

1. Make vision and strategy clear	Take a strategic, evidence-based approach – know your inequalities gaps, and what conditions are responsible.
2. Extend leadership and engagement	Lead from the top, with chief executives, directors and clinical leadership playing their part.
3. Make partnership work	Ensure that partnerships are effective at the level of executive/ non-executive members, but also among middle management and frontline staff.
4. Get system and scale right	Turn effective personal health and community health interventions into population-level interventions by addressing ad hoc and patchy delivery. Scale action to the size of the problem, modelling the numbers where possible.
5. Adjust workforce	Consider and address the workforce implications of industrial-scale programmes; e.g. register management, taking into account the necessary scale of activity and balancing the skill mix to obtain cost-effective, sustainable systems.
6. Strengthen primary care	Ensure that the quality and quantity of primary care available in disadvantaged areas meets needs and is well organised.
7. Find the missing thousands	Be proactive in seeking out people who already have disease or are at high risk but are accessing services sub-optimally or not at all. Use prevalence models to identify gaps between expected and actual numbers on registers. Pursue them systematically through practice records, and by outreach into communities.
8. Capitalise on community engagement	Support local authority partners in the development of neighbourhood and community infrastructures to engage residents, particularly those ‘seldom seen, seldom heard’ in services. Use to ensure that services are responsive to needs, but also to help motivate and support appropriate health-seeking behaviour.
9. ‘Raise the bar’ on target achievement	Currently, performance targets may reduce incentives to address the patients who are harder to reach, those with more complex problems or those with greater levels of personal or contextual problems. Develop a strong QOF exemptions strategy to ensure that vulnerable patients are not removed from target registers before significant efforts have been made to achieve good outcomes.
10. Utilise population health intelligence	Ensure that there is adequate capacity and capability to generate population health information and intelligence in real time and on a business footing to drive programmes.

Hitting population-level targets

The HINST advocates that achieving percentage change at population level can be pursued in three main ways:

1. Population health level

Direct input at population level through legislation, regulation, taxation, and mass media, etc (e.g. preventing smoking in enclosed public spaces).

2. Personal health level

Applying effective personal health interventions (e.g. cholesterol management with statins, affordable warmth) systematically, and at a scale such that improvements add up to population-level change.

3. Community health level

Engaging, developing and empowering communities effectively and systematically enough that resulting health-improving and health-seeking behaviours lead to percentage change at population level.

The report explores what is needed in addition to a combination of these factors to reduce health inequalities.

The National Support Team for Health Inequalities 'Christmas tree' diagnostic

The online report includes the diagnostic model developed by HINST that identifies those factors which will determine whether a given intervention will achieve its best possible outcomes in a given population. It outlines the practical steps that can be taken to achieve health inequalities targets.

Balanced scorecards

Implementation of a Balanced Scorecard can improve both the quality of general practice generally and specific health inequality indicators targets, which should have a positive impact on health outcomes. A Balanced Scorecard is a collection of data from all general practices in a PCT area, across a range of locally relevant metrics. This will enable the management of performance and the identification of both developmental support needs and gaps in service provision.

Balanced Scorecards are fundamental to 'mapping the baseline' in order to ensure that primary care is contributing to health outcomes within a community, and to inform commissioning decisions. It should be set within the context of a primary care improvement plan or primary and community care strategy that aims to address health inequalities and improve life expectancy in the short term.

The HINST have identified some specific metrics that are of particular interest for addressing health inequalities and these should be incorporated in the balanced scorecard.

Audits

An ongoing programme of GP chronic disease management audits using a z-score-based 'dashboard' should be developed. A 'z-score' is a standardised measure that tells us relatively how the practice is doing compared to the average of all practices. The dashboard (or 'z-score' chart) becomes a method for displaying, on a single chart, a range of practice-level measures relating to a single care pathway, e.g. care for CHD, cancer or COPD. In this way, practices are able to see how they compare with other local practices in terms of need, primary care, prescribing, secondary care and tertiary care.

Taxonomy

The HINST has also highlighted the beneficial use of a taxonomy system that clusters practices with similar populations to enable like-with-like comparisons. A taxonomy of practices can be used by the PCT and practice based commissioning groups to identify opportunities to cluster similar practices in relation to the characteristics of the practice population in order to:

- allow practice performance on service outcomes to be benchmarked appropriately;
- enable the identification of 'cluster champions';
- allow practices sharing the same context to exchange experience on what works and what doesn't; and
- enable the PCT to provide different inputs to practices based on their demography.

Quality in General Practice

General practitioners provide the main access point to health care.

The HINST has stated that it has encountered clear examples where health outcomes were affected as much by the quality of a general practice as by levels of deprivation. The HINST have identified that there is significant variation between the best and the worst performers in general practice and that this inconsistent quality of general practice will deliver inequitable outcomes. We have examined a number of areas to see to what extent this could be the case in East Sussex.

Supporting Poor Performance

The PCTs in East Sussex have robust arrangements for monitoring and improving the quality of general practice. Where serious concerns are raised about a GP, the PCT will investigate the case and take the appropriate action. We have analysed all GP performance referrals since 2003 and found no association between GP poor performance and deprivation.

Quality and Outcomes Framework (QOF)

Payments are made to practices based on their quality of care as measured through the QOF. QOF contains a number of clinical and non-clinical indicators.

Clinical indicators cover different areas of clinical care such as:

- Structure: Is a disease register in place?
- Process: Is the indicator being measured and an appropriate intervention being made, across what percentage of the relevant population?
- Outcome: How well is the condition being controlled, across what percentage of the population?

The non-clinical indicators focus on achievement in a range of areas, such as records and information management, education and training, information for patients, practice management and medicines management. There are indicators focusing on patient experience, cervical screening, child health surveillance, maternity services and contraception.

Disease Registers

Some of the QOF clinical indicators are focused on developing and maintaining specific disease registers. The identification of patients who already have, or who are at risk of developing, disease and successful management of their condition/s are crucial to efforts to reduce premature mortality, morbidity and inequalities in health.

Many people with important health needs, including those with chronic problems, fail to present with them to health services. Chronic diseases require management, and unless those people at high risk or with an established disease are identified and registered, they will not be able to benefit from interventions such as primary and secondary prevention. There is therefore a need for health services to be proactive in seeking out people who already have a disease or are at a high risk but are accessing services sub-optimally or not at all.

The HINST have found that a significant proportion of the population in deprived areas fail to take advantage of the benefits services can offer. The reasons for this are variable and complex, and strategies for addressing the problem need to be based on local intelligence and insight, but they also need to be systematic. A common component of the problem is often that the service on offer is 'one size fits all'. Developing tailored menus of options for customer access can potentially make a considerable impact on inequalities in access and outcomes.

We have undertaken work to model the gaps between expected and actual numbers of people on disease registers. For CHD, cancer and COPD we have looked at the figures of the reported versus expected prevalence ratio for each condition for each GP practice and, second, the reported versus expected prevalence for each condition by deprivation quintile. These are available in the online report. The figures show considerable variation between practices in the ratio of reported versus expected prevalence for all three conditions.

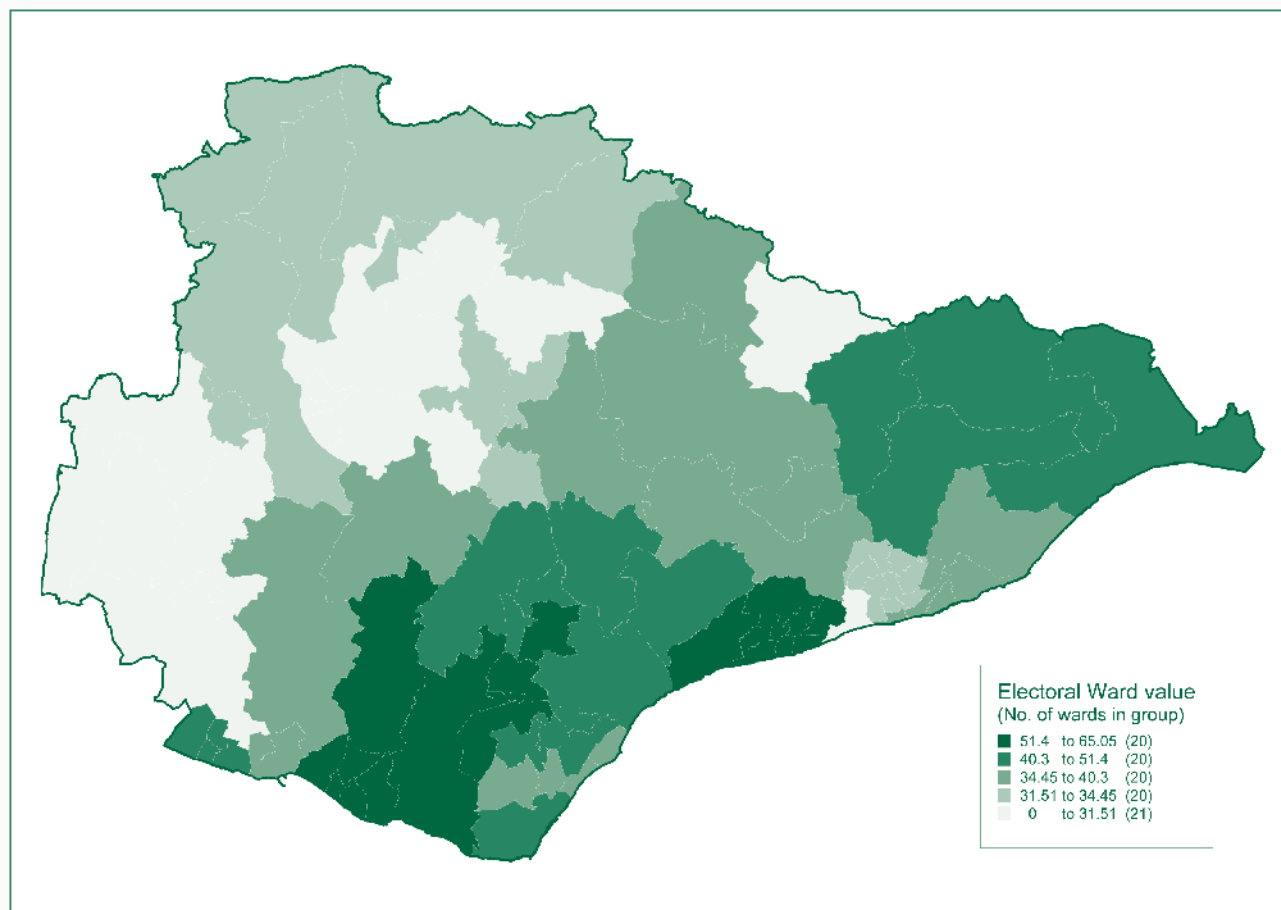
The ratio for CHD prevalence shows that the two most deprived quintiles have the lowest ratios (where 57% and 66% of expected CHD prevalence is recorded by the GP practices).

For cancer, the ratio of GP reported versus expected prevalence is much higher and there is also some association with deprivation with the lowest ratio in the most deprived quintile. The second and third quintiles also have lower ratios than the fourth and fifth quintiles.

For COPD, there is a strong inverse association with deprivation – the more deprived the quintile the higher the ratio. Eighty percent of the expected prevalence of COPD is reported in the most deprived quintile, reducing to 42% of expected prevalence reported in the least deprived quintile.

We have explored this further by looking at recorded CHD, cancer and COPD QOF prevalence in relation to mortality, and maps showing the prevalence the mortality ratio for these conditions across the county are available in our online report. The maps clearly demonstrate the difference between where those who are at risk of dying of these conditions live, based on primary care register prevalence data and actual mortality ratios taken from data in public health mortality files. By way of an example, the CHD maps are included here.

Figure 80: GP reported CHD prevalence, rate per 1,000 population, GP practice data modelled to electoral wards, 2007/08



Source: QOF data

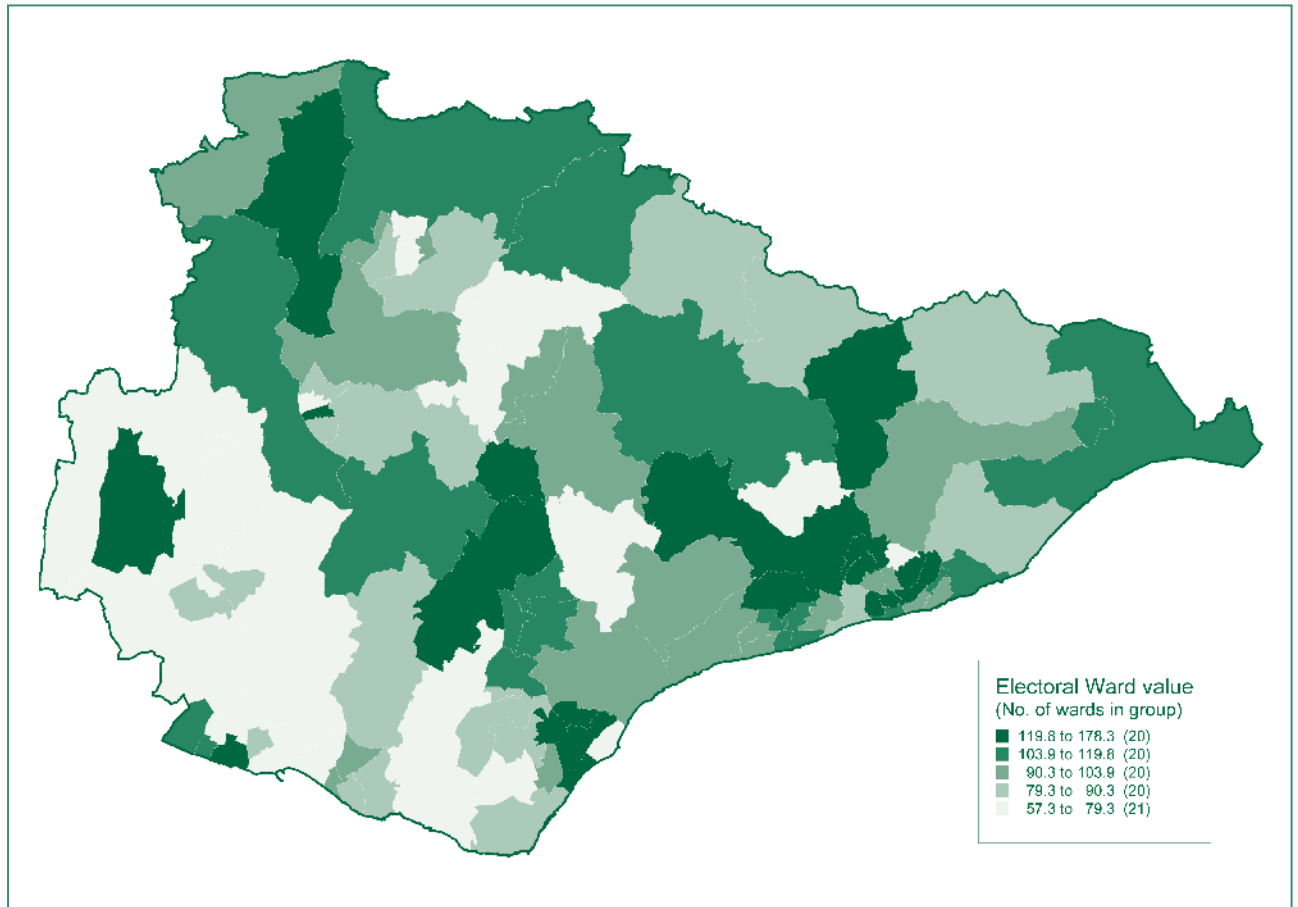
Figure 80 shows the prevalence and Figure 81 the mortality ratio for CHD across the county. The maps clearly demonstrate the difference.

This analysis demonstrates that there is more to be done in identifying patients for disease registers and indicates that large numbers of people are not accessing the services to improve the management of their disease, such as information, medication, regular checks on key clinical symptoms, and access to lifestyle change support.

QOF Clinical Management Indicators

There are several QOF indicators that focus on the management of patients once they are on a disease register. We analysed a selection of those indicators that relate to circulatory diseases, cancer and respiratory diseases to see if performance against them is associated with deprivation.

Figure 81: CHD standardised mortality ratios, East Sussex electoral wards, 2003–2007 (East Sussex = 100)



Source: ONS mortality data

We looked at 16 key indicators and found no or little difference between practice performance by deprivation quintile except for two indicators (BP5¹⁷ and Smoking 4¹⁸). For both these indicators, performance was higher the more deprived the quintile. In addition, we did not find an association between increased exception reporting and deprivation.

QOF Non-Clinical Indicators

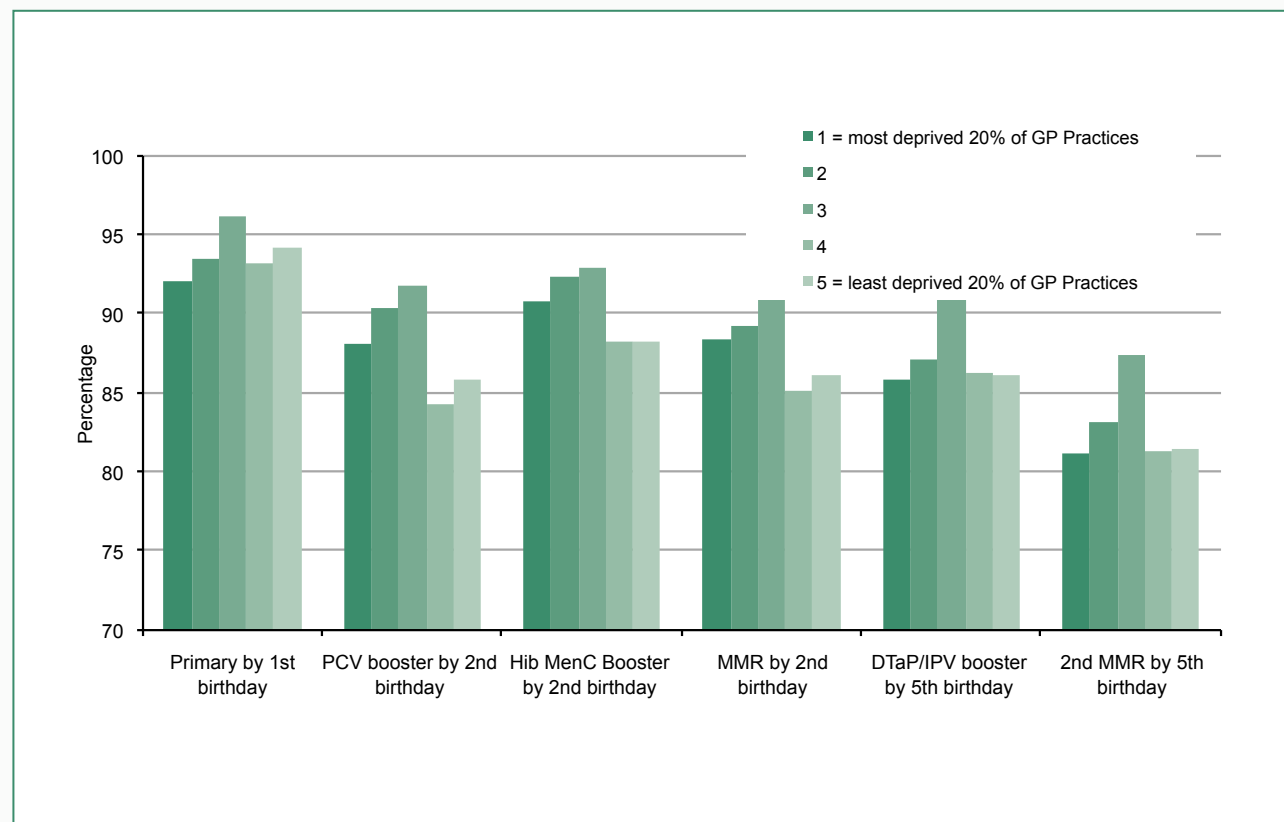
As detailed previously, there are a number of organisational indicators that aim to drive up the quality of practice administration and the provision of services available. We analysed performance against these indicators to see if there was an association with deprivation and found that the quality of practice administration and the provision of services available in the more deprived practices is comparable to that of the least deprived.

¹⁷ Hypertension (BP5) – The percentage of patients with hypertension in whom the last blood pressure (measured in the previous 9 months) is 150/90 or less.

¹⁸ Smoking 4 – The percentage of patients with any or any combination of the following conditions: coronary heart disease, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder

or other psychoses who smoke whose notes contain a record that smoking cessation advice or referral to a specialist service, where available, has been offered within the previous 15 months.

Figure 87: *Childhood immunisation coverage by deprivation quintile, East Sussex, 2009/1*



Source: East Sussex Child Health Systems

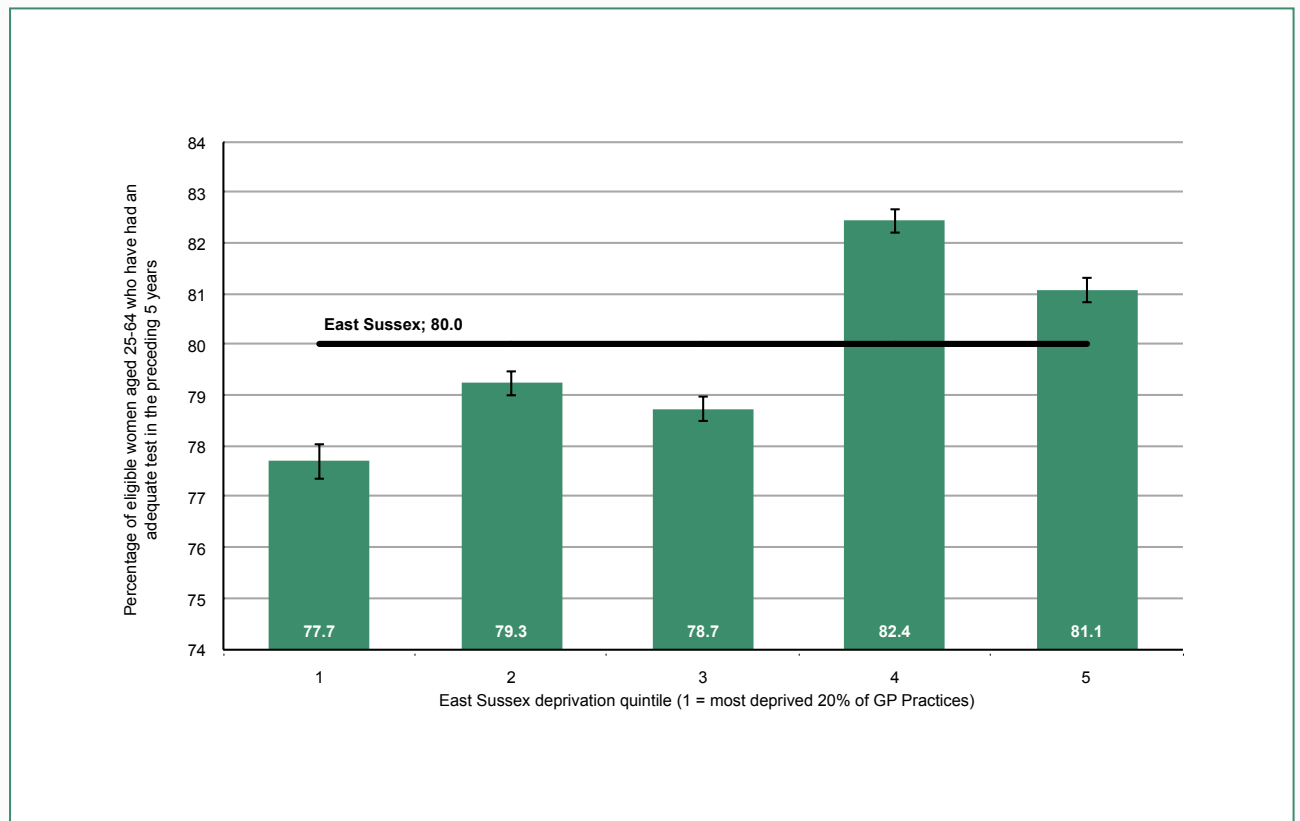
Childhood Immunisations

Childhood immunisation uptake shows an inverse association with deprivation. Figure 87 above shows that, for each immunisation, there is the same pattern, with the least deprived quintiles having the lowest uptake. This suggests that there are different factors, other than access to services, that affect vaccine uptake.

Cervical Screening

There is a clear evidence base that regular cervical screening saves lives. Figure 88 demonstrates an association between deprivation and uptake of cervical screening. The target is for at least 80% of women to have had a test in the last five years, but the figures indicate that only those GP practices in the least deprived quintiles achieved the target and that the lowest uptake was in the most deprived quintile.

Figure 88: Cervical screening with 95% confidence intervals by deprivation quintile, East Sussex, 2009/10



Source: Primary Care Support Services and IMD 2007

Patient registration with practices

Thousands of patients come off their doctors' lists every year. In most cases, this is because they move out of the practice's catchment area and for most people the convenience of the nearest practice is the main determinant of where they register.

When patients change practices, broad categories covering the reason for registration are recorded. A patient's dissatisfaction with the quality of the services they are receiving from their general practice is a potential reason for such a change and this could be apparent by patients registering with a new practice but without changing their address.

We found that there is an association between deprivation and patients changing practice but not changing postcode. Patients in the most deprived practices change their GP practice much more often than those in the least deprived. This may indicate that more patients in deprived areas are dissatisfied with the quality of the services they are receiving from their general practice. Important too is that, with the increased level of movement between practices, there is a question of the impact on continuity of health care for these patients, particularly in relation to long-term conditions and preventative health, etc.

The Marmot Review

The first section of this chapter has focussed on the HINST evidence on what will have an impact in a short timescale if delivered at a sufficient scale. Influencing the determinants of health requires multi-agency actions that will have an impact in the medium- to long-term.

In February 2010, The Marmot Review was published following an independent review of health inequalities in England. It proposes the most effective evidence-based strategies for reducing health inequalities in England from 2010. The Review:

1. Identifies the inequalities challenge facing England and the evidence most relevant to underpinning future policy and action.
2. Shows how this evidence could be translated into practice.
3. Advises on possible objectives and measures, building on the experience of targets on infant mortality and life expectancy.
4. Focusing solely on the most disadvantaged will not reduce health inequalities sufficiently. To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage. This is called proportionate universalism.
5. Action taken to reduce health inequalities will benefit society in many ways. It will have economic benefits in reducing losses from illness associated with health inequalities. These currently account for productivity losses, reduced tax revenue, higher welfare payments and increased treatment costs.
6. Economic growth is not the most important measure of our country's success. The fair distribution of health, wellbeing and sustainability are important social goals. Tackling social inequalities in health and tackling climate change must go together.
7. Reducing health inequalities will require action on six policy objectives:

Key messages of the review

A central message of the Review is that action is required across all the determinants of health and needs to involve all central and local government departments, as well as the third sector and private sector.

The Review contains many important findings, but the key messages are:

1. 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.
2. There is a social gradient in health. The lower a person's social position, the worse his or her health. Action should focus on reducing the gradient in health.
3. Health inequalities result from social inequalities. Action on health inequalities requires action across all the social determinants of health.
1. Give every child the best start in life
2. Enable all children, young people and adults to maximise their capabilities and have control over their lives
3. Create fair employment and good work for all
4. Ensure a healthy standard of living for all
5. Create and develop healthy and sustainable places and communities
6. Strengthen the role and impact of ill health prevention
8. Delivering these policy objectives will require action by central and local government, the NHS, the third and private sectors and community groups. National policies will not work without effective local delivery systems focused on health equity in all policies.
9. Effective local delivery requires effective participatory decision-making at local level. This can only happen by empowering individuals and local communities.

A framework for medium and long term action

The Review has two main aims: to improve health and wellbeing for all and to reduce health inequalities. To achieve this, there are two policy goals:

1. To create an enabling society that maximises individuals and community potential.
2. To ensure social justice, health and sustainability are at the heart of all policies.

Central to the Review is that disadvantage starts before birth and accumulates throughout life. This is reflected in the six policy objectives, with the highest priority being given to the first objective to give every child the best start in life.

The six policy objectives are underpinned by two policy mechanisms:

1. Considering equality and health equality in all policies across the whole of government, not just the health sector.
2. Effective evidence-based interventions and delivery systems.

Each of the policy objectives is supported by policy recommendations and suggested indicators to assess performance improvement in delivering review recommendations.

Making it happen

Action taken by the Department of Health and the NHS alone will not reduce health inequalities. The Marmot Review acknowledges the importance of medical and individual behaviour change interventions for improving health, but the review emphasises that it is only action across the social determinants of health that will reduce inequalities. Local government, therefore, is a pivotal partner.

Whilst action at a national level is required to implement some of the recommendations in the report there is a strong emphasis on local action and on empowering communities. It will be important, therefore, to ensure that there are robust arrangements for delivery across local partnerships.

The Review explored the lessons learned so far from recent strategies to reduce health inequalities and concluded that strategies that rely only on intervention in one part of the system will be insufficient to make the necessary difference to patterns of inequality. A whole-system approach is needed in which organisations and people work together with activity at national, regional, local and individual levels.

The Review concludes that the national and regional levels should be concerned with:

- a) The imperative of greater social justice and sustainability and the implications for policies to redistribute power and resources, and improve financial systems.
- b) Policies to maintain and improve universal health and welfare systems.
- c) Strategies and policy to enable public services to create and promote the conditions within which individuals, communities and the public take control of their own lives and have a voice.

Locally, it argues that the focus should be on:

- d) Creating opportunities for individuals and communities to set the agenda for change to define local problems and search out local solutions.
- e) Developing, commissioning and improving good quality, integrated local services co-produced with the public to achieve better outcomes for communities and individuals.
- f) Developing appropriate links between the levels and organisations to create partnerships to address health inequalities and a shift in power and resources towards local communities.

Next Steps

1. The ten major lessons learned by the HINST should inform work to reduce health inequalities in East Sussex.
2. Systems of delivery need to move from being project based to being programme based. The HINST set of criteria should be used to achieve this.
3. The HINST diagnostic model that identifies factors that will determine whether a given intervention will achieve its best possible outcome in a given population should be utilised.
4. A taxonomy system should be developed to group general practices with similar populations to enable like-with-like comparisons.
5. A GP Practice Balanced Scorecard should be implemented as it can improve the quality of general practice, which will have a positive impact on health outcomes. Specific metrics that are of particular interest for addressing health inequalities should be included.
6. An ongoing programme of general practice chronic disease management audits using a z-score-based dashboard should be developed to focus on key care pathways, e.g. CHD, cancer and COPD care.
7. Implementation of the Marmot Review requires a multi-agency approach and strategies for implementation. East Sussex partners need to consider the Marmot Review and agree how to implement the recommendations through their work. The framework of indicators to assess performance improvement in delivery review recommendations will assist.

Recommendations

1. The ten major lessons learned by the Health Inequalities National Support Team (HINST) should inform work to reduce health inequalities in East Sussex by using programme-based delivery and the HINST diagnostic model for interventions.
2. Improving the quality of primary care is one of the key factors to reducing health inequalities and it is recommended that the following actions are taken:
 - a) A GP Practice Balanced Scorecard, including specific metrics to reduce health inequalities, should be implemented.
 - b) Develop an ongoing programme of general practice chronic disease management audits using a z-score-based dashboard to focus on the key life expectancy-gap contributory care pathways, such as CHD, cancer and COPD care.
 - c) A system should be developed to group general practices with similar populations to enable like-with-like comparisons.
3. An East Sussex Health Inequalities Implementation Reduction Plan needs to be developed to implement the Marmot Review and the recommendations outlined in this report.





