

Director of Public Health
Annual Report 2010/11



Reducing Health Inequalities in East Sussex



East Sussex Downs & Weald PCT

Hastings & Rother PCT

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Contents

Foreword	10
Executive Summary	12
Introduction	14
Chapter 1: What's Important about Health Inequalities?	16
What are Health Inequalities and What Causes Them?	17
Why Addressing Health Inequalities is Important?	18
How do you Measure Health Inequalities?	21
Chapter 2: What is the Health Inequalities Gap in East Sussex?	44
Main Contributors to Life Expectancy Gap	45
East Sussex	46
Eastbourne	47
Hastings	50
Lewes	53
Rother	56
Wealden	59
Joint Strategic Needs Assessment Programme	62
JSNA Indicator Scorecards	62
East Sussex	63
Eastbourne	68
Hastings	72
Lewes	77
Rother	82
Wealden	86
Comprehensive Needs Assessments	91
Black and Minority Ethnic Groups	91
Offender Health	95
Focused Work on Increasing Life Expectancy	97

Contents

Chapter 3: How are we Tackling Health Inequalities?	102
Promoting Healthy Lifestyles	103
Alcohol	104
Smoking and Tobacco Control	109
Obesity	115
Sexual Health	121
Mental Health and Wellbeing	124
The Top 3 Causes of the Life Expectancy Gap:	
Circulatory Diseases, Cancer, Respiratory Diseases	129
Children and Young People	135
Older People	149
Chapter 4: How can we Achieve More and Move Forward Faster?	158
Quality in General Practice	160
Implementing the Health Inequalities	
National Support Team Evidence Base	177
The Marmot Review	184
Appendix I	188
Glossary	204
Abbreviations	205
Further information	206

List of figures

Figure 1:	The main determinants of health	17
Figure 2:	Difference between life expectancy and disability-free life expectancy among males at birth, East Sussex districts and boroughs, 2001	20
Figure 3:	Difference between life expectancy and disability-free life expectancy among females at birth, East Sussex districts and boroughs, 2001	20
Figure 4:	Index of Multiple Deprivation 2007 scores by LSOA grouped by East Sussex districts and boroughs	22
Figure 5:	Index of Multiple Deprivation 2007, LSOAs by East Sussex deprivation quintiles	23
Figure 6:	Infant mortality rate with 95% confidence intervals, East Sussex districts and boroughs, 2006–2008	24
Figure 7:	Infant mortality rate, East Sussex electoral wards, 1990–2007	25
Figure 8:	Male life expectancy, East Sussex districts and boroughs, 1991–1993 to 2006–2008	26
Figure 9:	Female life expectancy, East Sussex districts and boroughs, 1991–1993 to 2006–2008	26
Figure 10:	Life expectancy at birth, East Sussex districts and boroughs, 2006–2008	27
Figure 11:	Life expectancy at birth, East Sussex electoral wards, 2005–2007	27
Figure 12:	Life expectancy at birth by deprivation quintile with 95% confidence intervals, Eastbourne, 2004–2008	28
Figure 13:	Life expectancy at birth by deprivation quintile with 95% confidence intervals, Hastings, 2004–2008	29
Figure 14:	Life expectancy at birth by deprivation quintile with 95% confidence intervals, Lewes, 2004–2008	29
Figure 15:	Life expectancy at birth by deprivation quintile with 95% confidence intervals, Rother, 2004–2008	30
Figure 16:	Life expectancy at birth by deprivation quintile with 95% confidence intervals, Wealden, 2004–2008	30
Figure 17:	All age all cause mortality, NHS East Sussex Downs and Weald, 1993–2008 (directly age-standardised rate per 100,000 population)	31
Figure 18:	All age all cause mortality, NHS Hastings and Rother, 1993–2008 (directly age-standardised rate per 100,000 population)	32
Figure 19:	All age all cause standardised mortality ratios, East Sussex electoral wards, 2005–2007 (East Sussex = 100)	32
Figure 20:	Life expectancy at birth by deprivation deciles, showing the SII, NHS East Sussex Downs and Weald, males, 2004–2008	33

List of figures

Figure 21: Life expectancy at birth by deprivation deciles, showing the SII, NHS East Sussex Downs and Weald, females, 2004–2008	34
Figure 22: Life expectancy at birth by deprivation deciles, showing the SII, NHS Hastings and Rother, males, 2004–2008	35
Figure 23: Life expectancy at birth by deprivation deciles, showing the SII, NHS Hastings and Rother, females, 2004–2008	35
Figure 24: PCT SII (gap in life expectancy) with 95% confidence intervals, males, 2001–2005 to 2004–2008	37
Figure 25: PCT SII (gap in life expectancy) with 95% confidence intervals, females, 2001–2005 to 2004–2008	37
Figure 26: All cancer mortality, all persons aged under 75 years, 1993–1995 to 2010–2012 (directly age-standardised rate per 100,000 population)	38
Figure 27: All circulatory disease mortality, all persons aged under 75 years, 1993–1995 to 2010–2012 (directly age-standardised rate per 100,000 population)	39
Figure 28: Standardised mortality ratios for deaths from all circulatory diseases in persons aged under 75, East Sussex electoral wards, 2003–2007	39
Figure 29: Rural/urban classification by lower super output area in East Sussex	40
Figure 30: Index of Multiple Deprivation 2007 scores at LSOA level by urban/rural classification in East Sussex	41
Figure 31: Average IMD scores for urban and rural areas in East Sussex	41
Figure 32: Life expectancy at birth with 95% confidence intervals, by urban/rural classification in East Sussex, 2006–2008	42
Figure 33: Breakdown of life expectancy gap between the most deprived and least deprived quintile in Eastbourne by cause of death, 2001–2005	47
Figure 34: Possible gain in life expectancy in Eastbourne, 2001–2005	48
Figure 35: Breakdown of life expectancy gap between the most deprived and least deprived quintile in Hastings by cause of death, 2001–2005	50
Figure 36: Possible gain in life expectancy in Hastings, 2001–2005	51
Figure 37: Breakdown of life expectancy gap between the most deprived and least deprived quintile in Lewes by cause of death, 2001–2005	53
Figure 38: Possible gain in life expectancy in Lewes, 2001–2005	54
Figure 39: Breakdown of life expectancy gap between the most deprived and least deprived quintile in Rother by cause of death, 2001–2005	56
Figure 40: Possible gain in life expectancy in Rother, 2001–2005	57
Figure 41: Breakdown of life expectancy gap between the most deprived and least deprived quintile in Wealden by cause of death, 2001–2005	59
Figure 42: Possible gain in life expectancy in Wealden, 2001–2005	60
Figure 43: Projection of black and minority ethnic groups in East Sussex to 2020	92
Figure 44: Age structure of ethnic groups in East Sussex, 2007	93
Figure 45: International in-migrant GP registrations, East Sussex districts and boroughs, 2000/01–2007/08	95

Figure 46: Life expectancy gap in East Sussex between wards with the lowest life expectancy at birth and the rest, 2003/04/05–2009/10/11	99
Figure 47: Costs across communities associated with alcohol misuse	105
Figure 48: Number of directly attributable hospital admissions, East Sussex districts and boroughs, 2002/03–2009/10	106
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)	107
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)	110
Figure 51: Modelled estimates of current smoking amongst adults aged 16 years and over, East Sussex electoral wards, 2003–2005	111
Figure 52: Factors associated with stopping smoking	111
Figure 53: 4-week quitters per 100,000 population aged over 16 years, East Sussex electoral wards, 2009/10	113
Figure 54: Percentage of children in Reception Year overweight or obese with 95% confidence intervals, East Sussex PCTs, 2007/08 and 2008/09	117
Figure 55: Percentage of children in Year 6 overweight or obese with 95% confidence intervals, East Sussex PCTs, 2007/08 and 2008/09	117
Figure 56: Prevalence of underweight, overweight and obesity by income deprivation affecting children, Reception Year, 2008/09	118
Figure 57: Prevalence of underweight, overweight and obesity by income deprivation affecting children, Year 6, 2008/09	118
Figure 58: Obesity prevalence estimates for adults aged 16 years and over in East Sussex, 2000–2002 to 2006–2008	119
Figure 59: Number of sexual health screens/HIV antibody tests at East Sussex GUM clinics, 2002–2009	123
Figure 60: New Horizons Framework – five areas to improve mental wellbeing	125
Figure 61: Income Deprivation Affecting Children Index 2007, electoral wards in East Sussex	135
Figure 62: Under-18 conception rate for East Sussex, 1997–2008 (rate per 1,000 females aged 15–17 years)	139
Figure 63: Under-18 conception rate with 95% confidence intervals by deprivation quintile, East Sussex, 2005–2007	140
Figure 64: Percentage of mothers initiating breastfeeding with 95% confidence intervals by deprivation quintile, East Sussex, 2008/09	144
Figure 65: Prevalence of breastfeeding at six to eight weeks amongst infants of known status with 95% confidence intervals, by East Sussex deprivation quintile, 2008/09	145
Figure 66: Pupils achieving 5 A* to C grades for GCSE including English and Maths by deprivation quintile, East Sussex, 2008/09 academic year	147

List of figures

Figure 67: Income Deprivation Affecting Older People Index (IDAOP) 2007, East Sussex electoral wards	149
Figure 68: Life expectancy at age 65 years with 95% confidence intervals, East Sussex districts and boroughs, 2006–2008	150
Figure 69: Disability-free life expectancy at age 65 years with 95% confidence intervals, males, East Sussex districts and boroughs, 1999–2003	150
Figure 70: Disability-free life expectancy at age 65 years with 95% confidence intervals, females, East Sussex districts and boroughs, 1999–2003	151
Figure 71: Causes of death among males aged 65 years and over resident in East Sussex, 2008	152
Figure 72: Causes of death among females aged 65 years and over resident in East Sussex, 2008	152
Figure 73: Performance referrals per 100,000 registered population with 95% confidence intervals by deprivation quintile, East Sussex, 2009/10	161
Figure 74: Practice prevalence of CHD based on GP QOF Registers, 2008/09 versus expected prevalence of CHD by deprivation quintile, East Sussex	162
Figure 75: Prevalence of CHD based on GP QOF Registers, 2008/09 versus expected prevalence of CHD by deprivation quintile, East Sussex	163
Figure 76: Practice prevalence of cancer based on GP QOF Registers, 2008/09 versus expected prevalence of cancer by deprivation quintile, East Sussex	163
Figure 77: Prevalence of cancer based on GP QOF Registers, 2008/09 versus expected prevalence of cancer by deprivation quintile, East Sussex	164
Figure 78: Practice prevalence of COPD based on GP QOF Registers, 2008/09 versus expected prevalence of COPD by deprivation quintile, East Sussex	165
Figure 79: Prevalence of COPD based on GP QOF Registers, 2008/09 versus expected prevalence of COPD by deprivation quintile, East Sussex	165
Figure 80: GP-reported CHD prevalence, rate per 1,000 population, GP practice data modelled to electoral wards, 2007/08	166
Figure 81: CHD standardised mortality ratios, East Sussex electoral wards, 2003–2007 (East Sussex = 100)	167
Figure 82: GP-reported cancer prevalence, rate per 1,000 population, GP practice data modelled to electoral wards, 2007/08	168
Figure 83: Cancer standardised mortality ratios, East Sussex electoral wards, 2003–2007 (East Sussex = 100)	169
Figure 84: GP-reported COPD prevalence, rate per 1,000 population, GP practice data modelled to electoral wards, 2007/08	170
Figure 85: COPD standardised mortality ratios, East Sussex electoral wards, 2003–2007 (East Sussex = 100)	171
Figure 86: Achievement of QOF non-clinical indicators by deprivation quintile, East Sussex, 2009/10	174

Figure 87: Childhood immunisation coverage by deprivation quintile, East Sussex, 2009/10	174
Figure 88: Cervical screening with 95% confidence intervals by deprivation quintile, East Sussex, 2009/10	175
Figure 89: Percentage of patients who have changed the GP practice they are registered with but have not changed their postcode of residence (April 2009 compared to April 2010)	176
Figure 90: Achieving change at population level	178
Figure 91: Commissioning healthcare for best outcomes	179
Figure 92: Conceptual framework for action	185

List of tables

Table 1: Life expectancy and disability-free life expectancy among males at birth, 2001	19
Table 2: Life expectancy and disability-free life expectancy among females at birth, 2001	19
Table 3: Domains within the overall IMD 2007 score	21
Table 4: IMD 2007 score and rank for districts and boroughs in East Sussex	22
Table 5: Life expectancy by deprivation deciles, males and females, 2004–2008, NHS East Sussex Downs and Weald	34
Table 6: Life expectancy by deprivation deciles, males and females 2004–2008, NHS Hastings and Rother	36
Table 7: Rank out of 152 PCTs (1 is the worst/largest inequality gap)	36
Table 8: Significant differences in mortality rates in Eastbourne	49
Table 9: Significant differences in mortality rates in Hastings	52
Table 10: Significant differences in mortality rates in Lewes	55
Table 11: Significant differences in mortality rates in Rother	58
Table 12: Significant differences in mortality rates in Wealden	61
Table 13: Numbers and percentages of the black and minority ethnic populations by local authority, 2001 and 2007, ONS	92
Table 14: Summary of relative frequency of diseases in black and minority ethnic groups compared with the majority population	93
Table 15: The 20 wards with the lowest life expectancy in East Sussex, 2003–2005	98
Table 16: Investing in Life Programme targets, progress to date	99
Table 17: Deprivation category for the LSOAs within the Investing in Life wards	100
Table 18: Classifications of underweight, overweight and obese	116
Table 19: Estimated prevalence of obesity for adults aged 16 years and over, 2003–2005	119
Table 20: Chlamydia screening rates 2009/10	122

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 is intended to be a useful online source of inequalities data and there will also be a summary report of the key findings and recommendations. It describes the current position on health inequalities across East Sussex and the current 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 despite the challenging and complex circumstances, as the consequences of the recession for health and wellbeing will impact on local people for some time.

This document is intended to be used as a resource for our joint inequalities work now and in the future, and I would like to thank all who made contributions to this 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
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Executive Summary

Reducing Health Inequalities in East Sussex examines health inequalities in East Sussex, mainly at local authority level. It is not the type of report you read from cover to cover. Information is presented so that it can be easily identified and extracted to produce local authority level health inequality profiles.

A brief overview of each chapter of the 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:

- Eastbourne Strategic Partnership
- Hastings Strategic Partnership
- Lewes District Strategic Partnership
- Rother Strategic Partnership
- Wealden Strategic Partnership
- East Sussex Strategic Partnership

The six LSPs have numerous members, including the primary care trusts (PCTs), police, fire and rescue service, businesses, voluntary and community groups and 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*. The strategy contains nine themes covering strategic priorities:

- The economy, jobs and prosperity
- Transport, access and communications
- Housing
- Environment and climate change
- Education, learning and skills
- Health and wellbeing
- Community safety
- Community strength and leadership
- Culture, sports and leisure

There are also two cross-cutting priority age groups: Children and Young People, and Older People.

The strategic priority for the health and wellbeing theme is:

“To reduce health and care inequalities within and between communities and improve overall health and wellbeing by 2026”

While the strategy covers the whole of East Sussex, it also has a strong local focus that helps identify inequalities within and between local areas. The links between inequalities in the health and wellbeing theme and inequalities in other themes, such as economy, jobs and prosperity or housing, are well understood by LSP partners. A commitment to ‘narrow the gap’ runs throughout Pride of Place and is found in the many delivery plans that are the means of implementation. In delivering all the strategic priorities for Pride of Place, partners have stated:

“... in relation to everything we do, we must... reduce inequalities and narrow the gap between the least and most deprived individuals and communities, whilst raising the quality of life for everyone...”

Pride of Place covers the period 2008–2026 and, as such, is a long-term plan to achieve a better quality of life for all local people. It provides a framework for action.

The need to address the inequalities set out in Pride of Place has been carried through into the East Sussex Local Area Agreement (LAA). This is the agreement between local partners and central Government on which national priorities are also key local priorities for East Sussex. The second East Sussex LAA 2008–2011 is in its final year: 2010/11. There are 42 targets in the LAA and nearly all of them have the potential to have a direct or indirect impact on reducing health inequalities.

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.

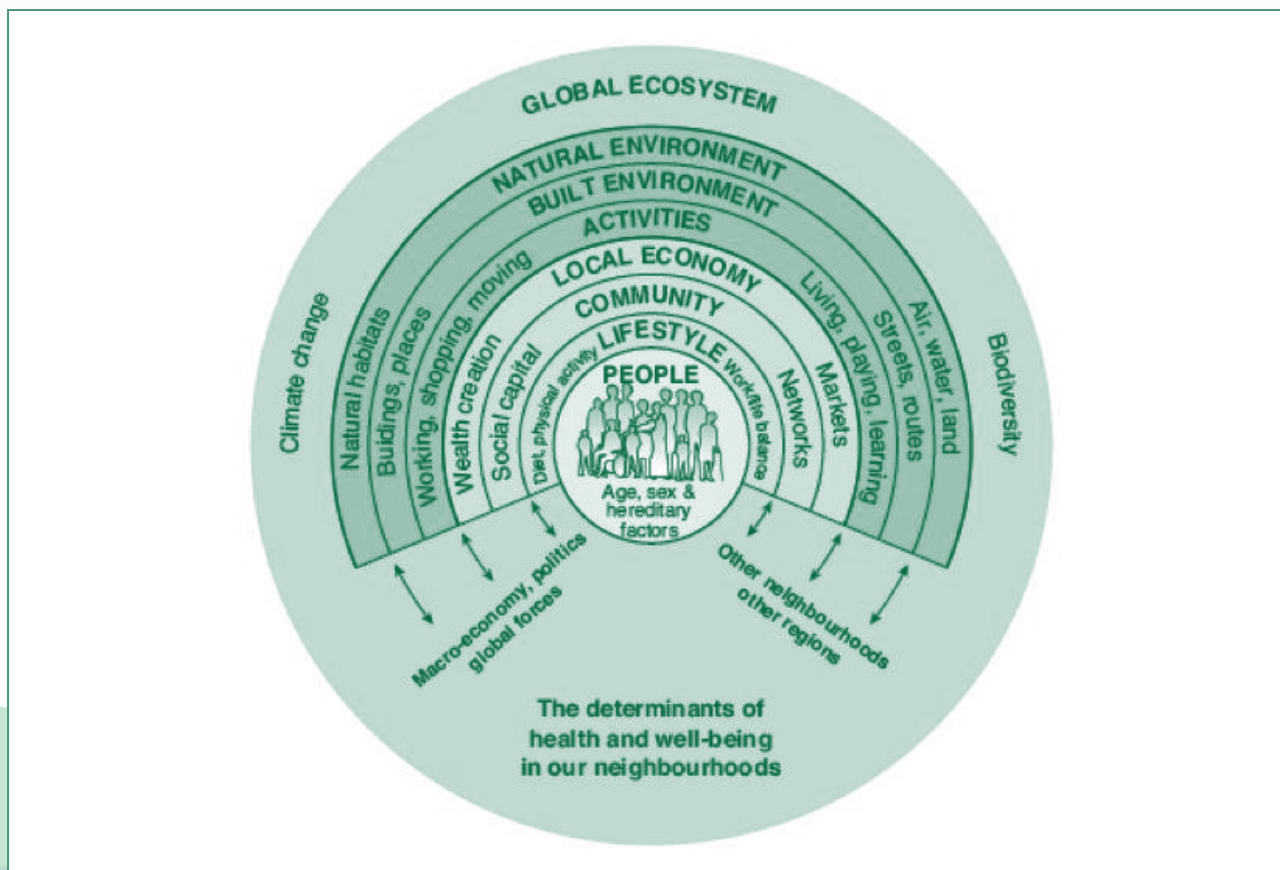
There is good partnership working in East Sussex and improvements are being made to people’s health and wellbeing. This is a strong basis for achieving further reductions in health inequalities by implementing national best practice and the recommendations from this public health report.

What's Important about Health Inequalities?



What are Health Inequalities and What Causes Them?

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.

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.

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.

Unemployment increases the odds of marital dissolution by 70% after job loss, and men and women who lose their jobs are 33% and 83% more likely, respectively, to experience relationship breakdown than those who stay in their jobs. Strong relationships are known to protect against suicide risk.

International evidence shows men and women who lost their jobs due to the closure of their work establishment had a 22% and 44% increased risk, respectively, of alcohol-related hospitalisation over the subsequent 12-year period.⁴

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.⁴

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.

⁴ *Learning From the Past: Tackling worklessness and the social impacts of recession.* Cabinet Office, 2009.

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.

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.

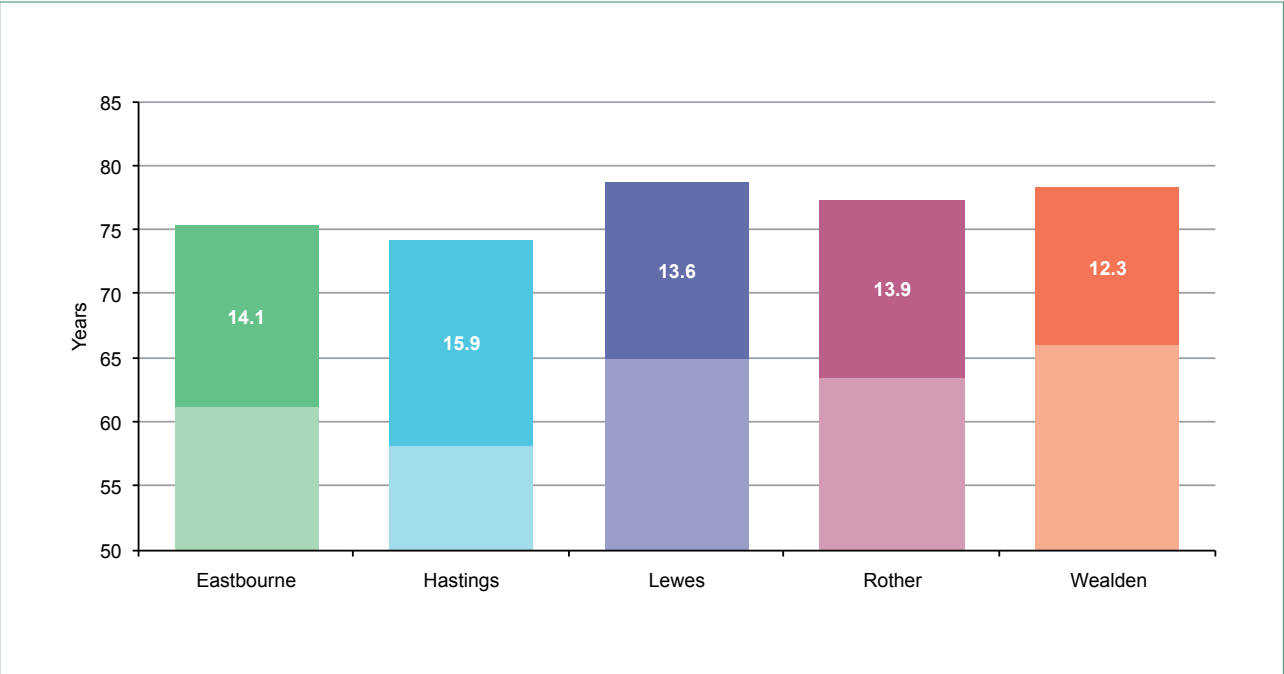
Life expectancy and disability-free life expectancy is presented for 2001 as disability-free life expectancy is based on a 2001 Census question and cannot be updated until the 2011 Census.

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

Figures 2 and 3 present some of this information diagrammatically. The bars show total life expectancy, with the darker shaded part of each bar showing the number of years spent with a disability.

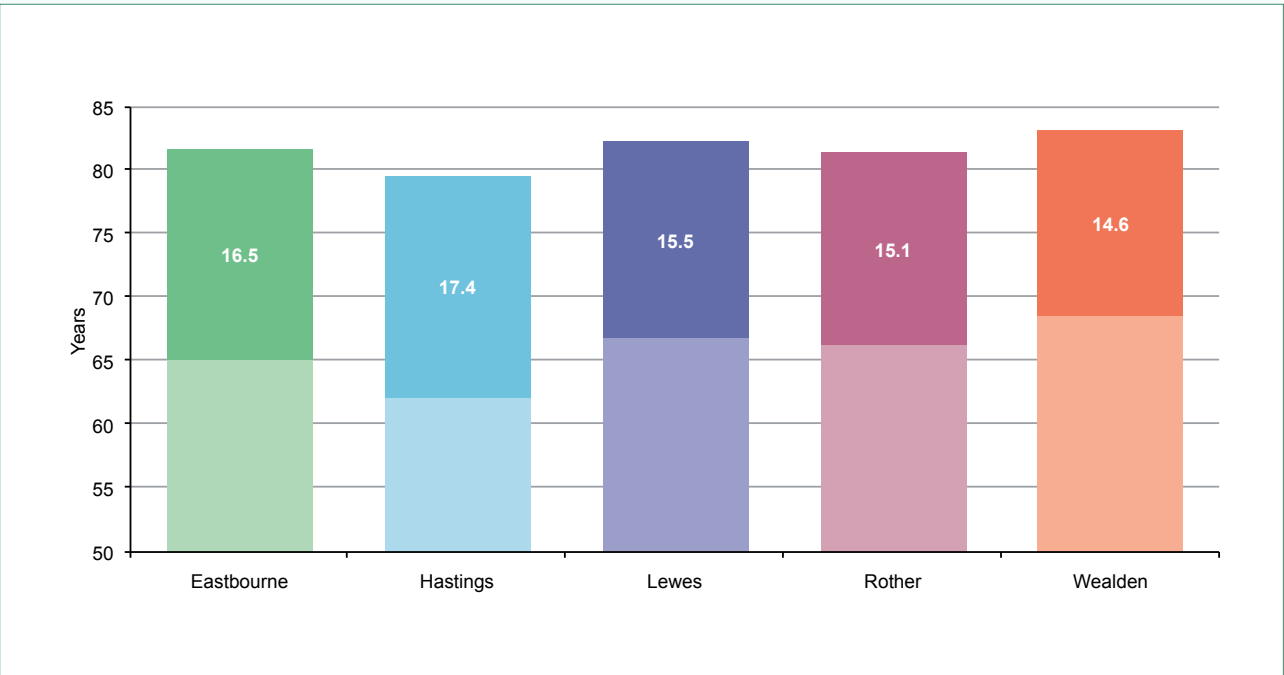
1 / What's Important about Health Inequalities?

Figure 2: *Difference between life expectancy and disability-free life expectancy among males at birth, East Sussex districts and boroughs, 2001*



Source: 2001 Census and ONS mortality data

Figure 3: *Difference between life expectancy and disability-free life expectancy among females at birth, East Sussex districts and boroughs, 2001*



Source: 2001 Census and ONS mortality data

How do you Measure Health Inequalities?

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

This section will identify some of the key data and methods used to quantify health inequalities in East Sussex and present the current position using those measures.

Index of Multiple Deprivation 2007 (IMD 2007)

The Index of Multiple Deprivation 2007 comprises a number of indicators grouped into seven domains (see Table 3) that cover a range of economic, social and housing issues. There are then combined into a single deprivation score for each small area in England. This allows the areas to be ranked relative to one another based on their level of deprivation. This is done at the lower super output area (LSOA) level, and there are 32,482 LSOAs in England and 327 in East Sussex. This indicator is not made available routinely and is updated centrally every three to four years.

Table 3: *Domains within the overall IMD 2007 score*

Domain	Weighting to overall score
Income Deprivation Domain	22.5%
Employment Deprivation Domain	22.5%
Health Deprivation and Disability Domain	13.5%
Education, Skills and Training Deprivation Domain	13.5%
Barriers to Housing and Services Domain	9.3%
Crime Domain	9.3%
The Living Environment Deprivation Domain	9.3%

1 / What's Important about Health Inequalities?

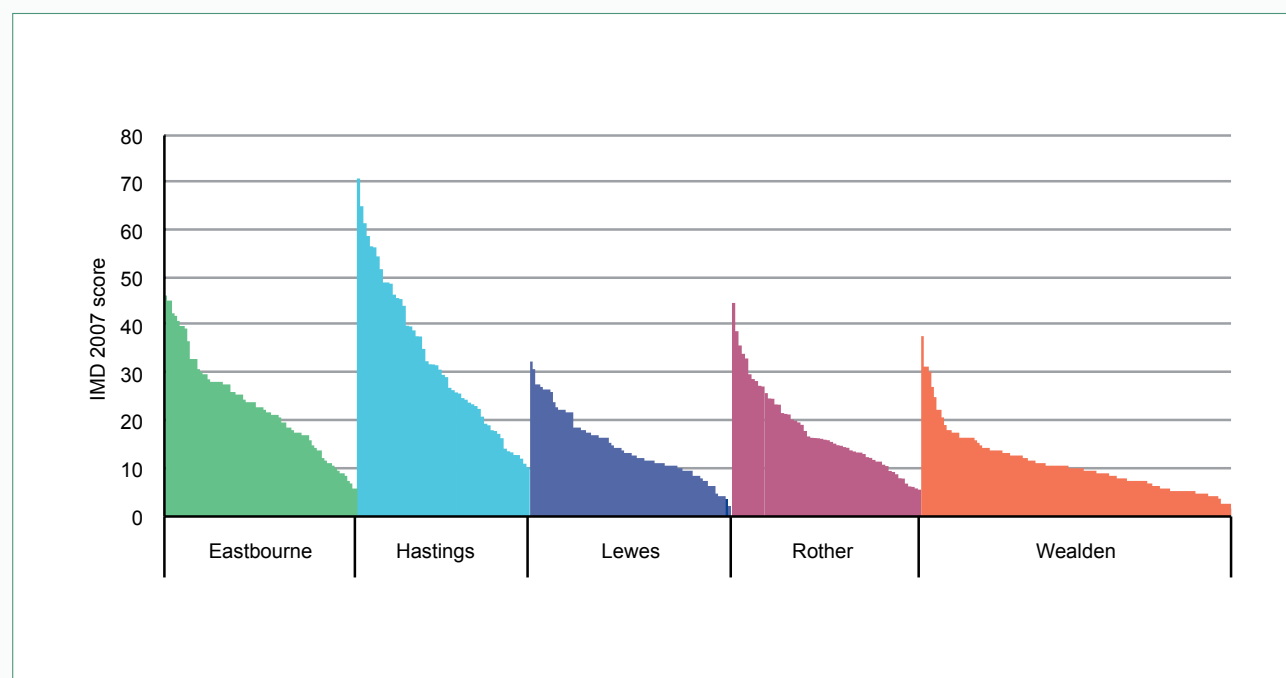
Table 4: IMD 2007 score and rank for districts and boroughs in East Sussex

Local authority	Average score across LSOAs within local authority	National rank of average score (1 = most deprived 354 = least deprived)	Number of LSOAs	Minimum LSOA score	Maximum LSOA score
Eastbourne	23.4	104	59	5.8	46.2
Hastings	32.2	31	53	10.3	71.0
Lewes	14.8	218	62	2.0	32.5
Rother	17.9	166	58	5.6	44.8
Wealden	10.9	284	95	1.6	37.8

Hastings is the 31st most deprived local authority area in England (out of 354) and is the most deprived in the South East region.

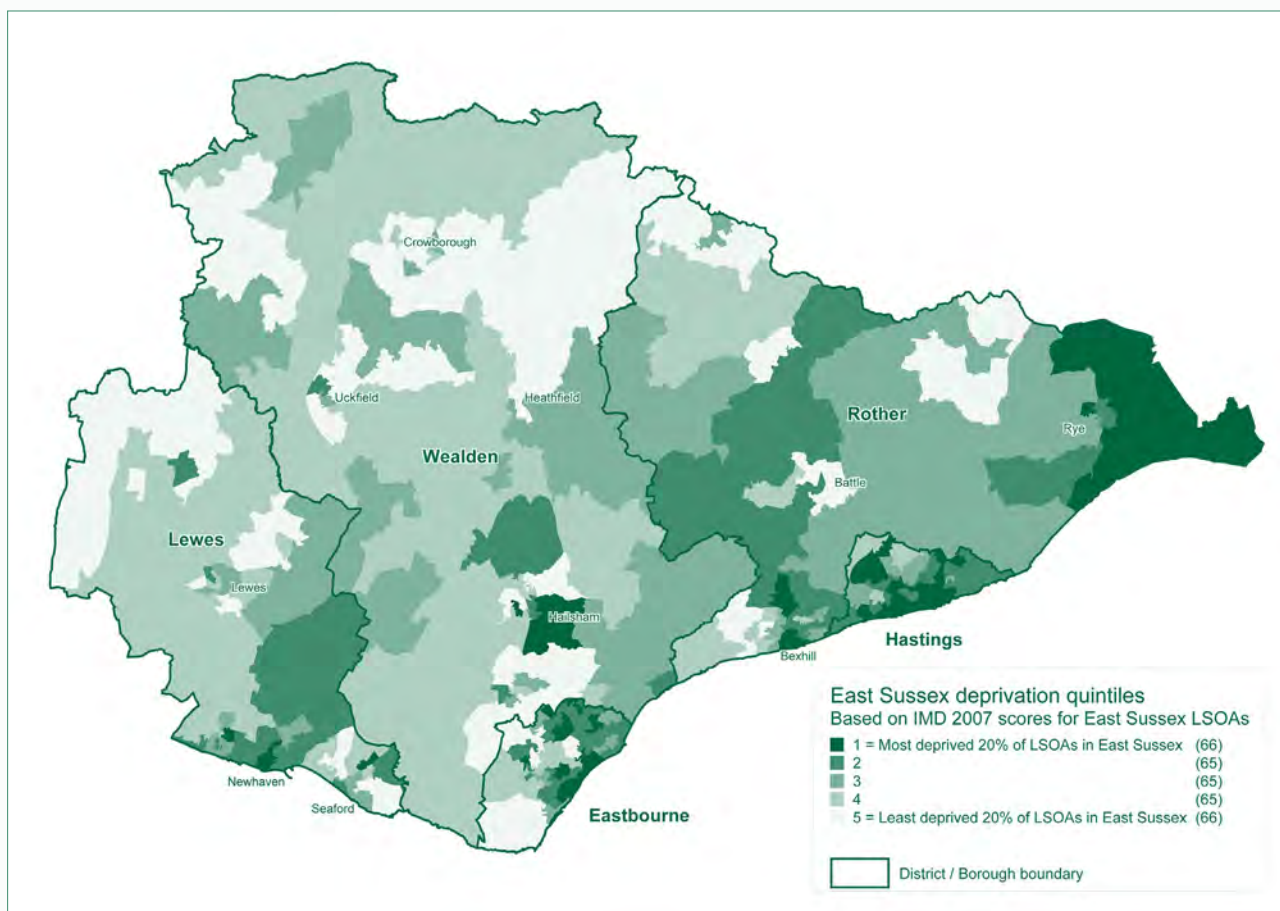
There is a wide variation of scores across the LSOAs by district, as displayed in Figure 4.

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



Source: Index of Multiple Deprivation 2007

Figure 5: Index of Multiple Deprivation 2007, LSOAs by East Sussex deprivation quintiles



Source: Index of Multiple Deprivation 2007

National health inequality targets

The NHS Plan, published in 2000,⁵ gave a commitment to the creation of national health inequalities targets.

The health inequalities national target is to:

- reduce health inequalities by 10 per cent by 2010, as measured by infant mortality and life expectancy at birth.

This target is underpinned by two more detailed objectives:

1. Starting with children under one year, to reduce by at least 10 per cent the gap in mortality between the routine and manual

group and the population as a whole by 2010, and

2. Starting with local authorities, to reduce by at least 10 per cent the gap in life expectancy at birth between the fifth of areas with the worst health and deprivation indicators (the Spearhead Group) and the population as a whole by 2010.

The target period '2010' is defined as the three-year period 2009–2011 and will include all deaths up to 31 December 2011.

Ultimate success will be measured by infant mortality and life expectancy at birth measures but all age, all cause mortality (AAACM) will be used as a proxy to measure progress.⁶

⁵ *The NHS Plan: A Plan for Investment, A Plan for Reform*. Crown Copyright, July 2000.

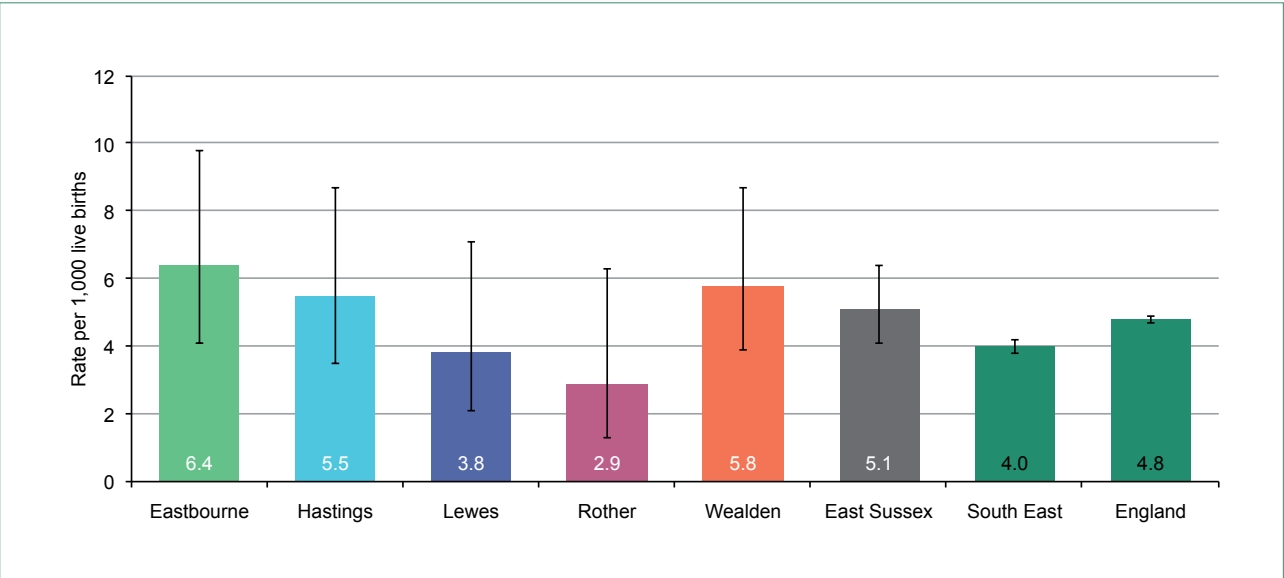
⁶ <http://www.statistics.gov.uk/hub/health-social-care/health-of-the-population/health-inequalities>

Infant Mortality

The infant mortality rate measures the number of deaths among infants under one year per 1,000 live births in an area. Between 2006 and 2008, there were 78 infant deaths across East Sussex, indicating an infant mortality rate of 5.1 per 1,000 live births. While this was higher than England (4.8 per 1,000) and the South East region (4.0 per 1,000), it was not statistically significantly higher, due to the relatively small number of events.

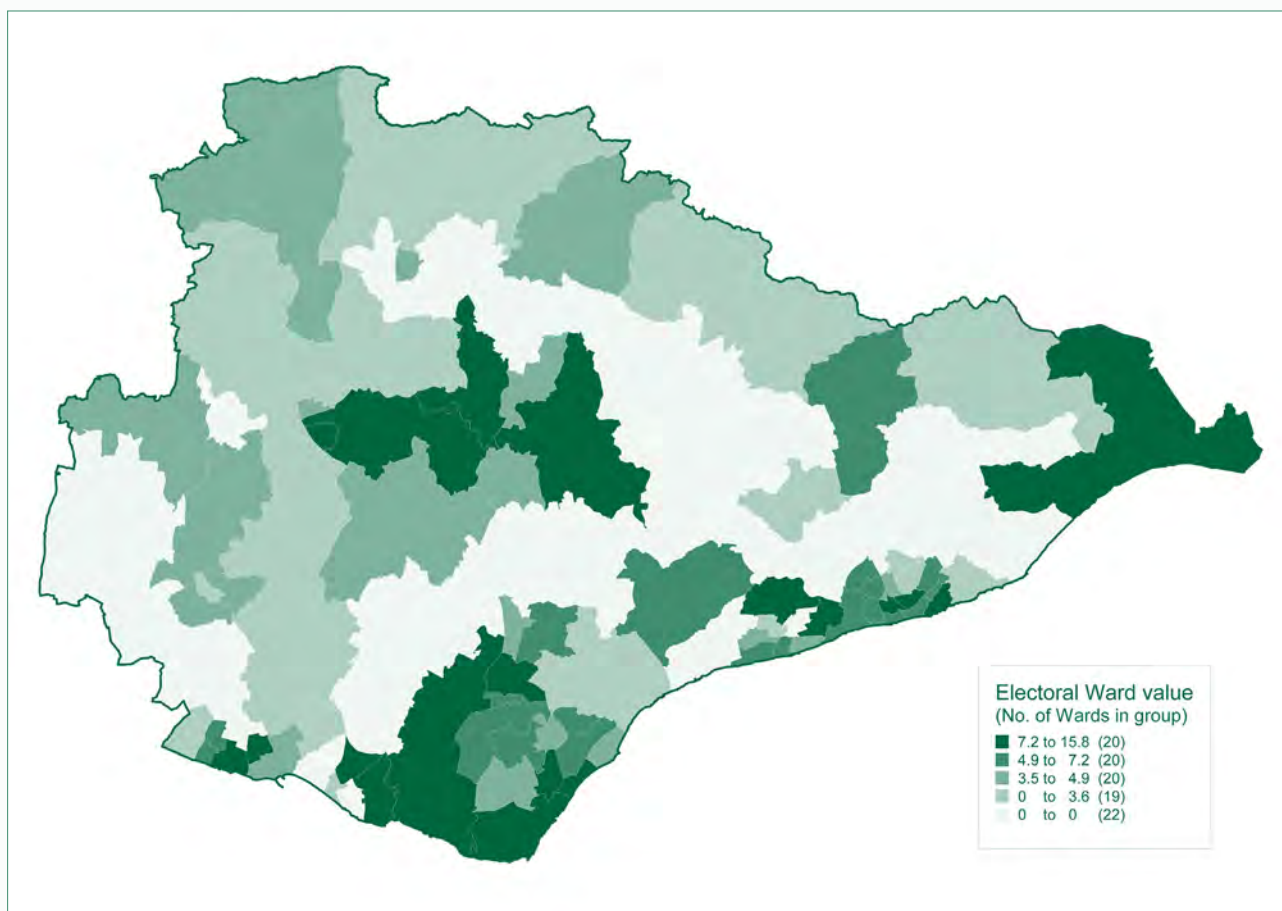
To analyse infant mortality rates in a smaller geographical area than districts and boroughs, several years of data were combined, which are mapped out below. At ward level, the infant mortality rate ranged from no infant deaths in 22 wards to 15.7 per 1,000 live births in Meads ward in Eastbourne.

Figure 6: Infant mortality rate with 95% confidence intervals, East Sussex districts and boroughs, 2006–2008



Source: Index of Multiple Deprivation 2007

Figure 7: Infant mortality rate, East Sussex electoral wards, 1990–2007



Source: Compendium of Clinical and Health Outcomes

Life expectancy

Life expectancy at birth is the average number of years a person would live if he or she experienced the age-specific mortality rates of the given area and time period for the rest of their life. 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.

Figures 8 and 9, set out the district and borough trends in life expectancy in relation to regional and national benchmarks. Lewes and Wealden are consistently above regional and national benchmarks for males and females, while Hastings is consistently below national and regional benchmarks.

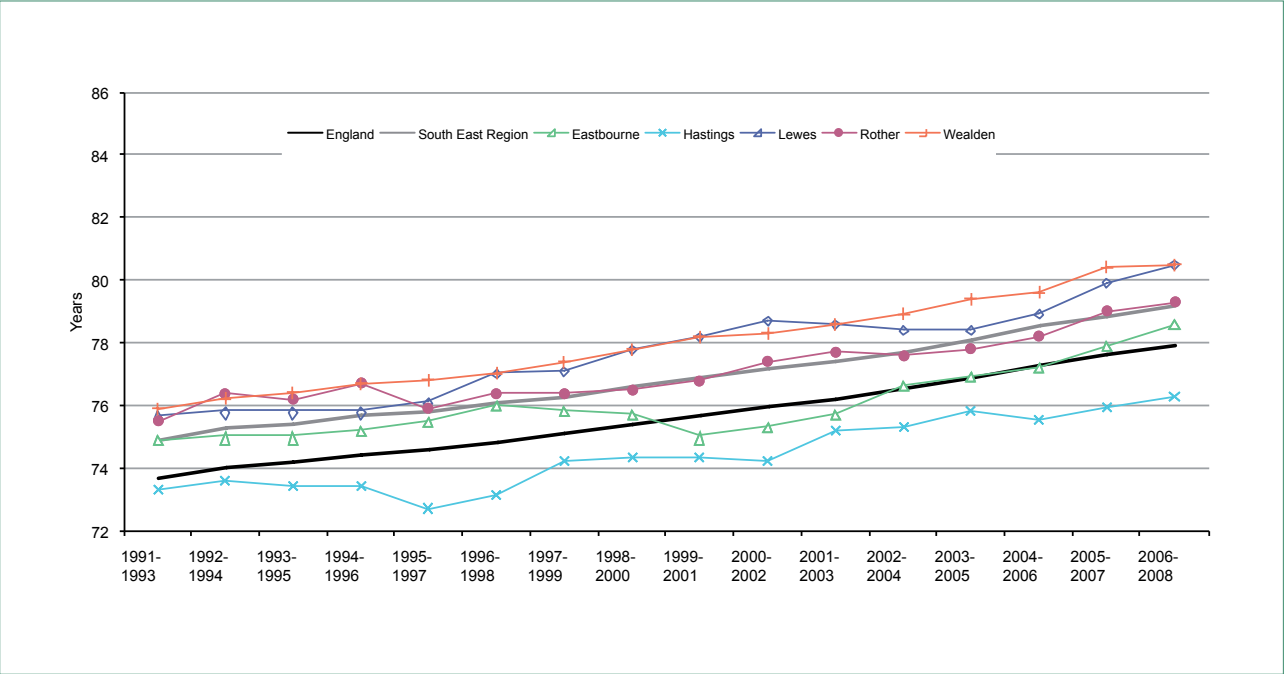
The latest life expectancy at birth figures are presented in Figure 10.

At a district and borough level in East Sussex, Hastings has the lowest life expectancy for males and females, and is the only area where life expectancy is below the national average.

At ward level, there is wide variation in life expectancy across East Sussex, ranging from 73.9 in Gensing (Hastings) to 88.7 in Crowborough Jarvis Brook (Wealden) district. The 20 wards with the lowest life expectancy for 2005–2007 are concentrated around Hastings, St Leonards and Eastbourne.

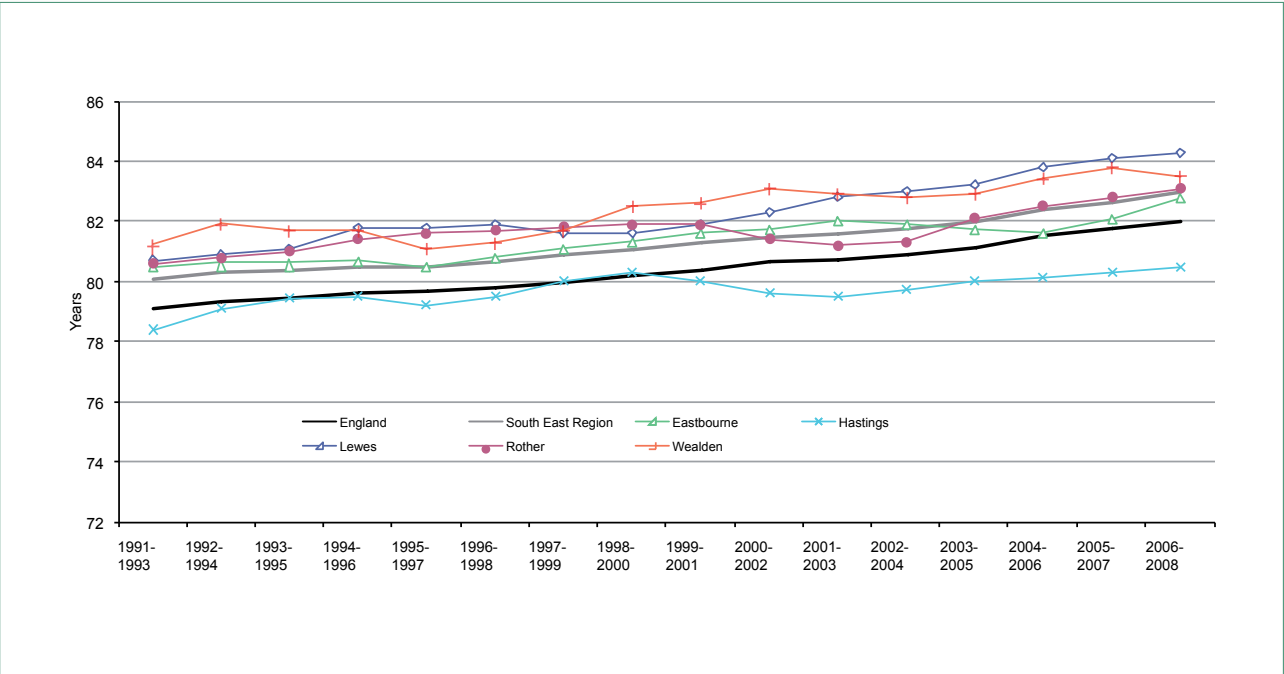
1 / What's Important about Health Inequalities?

Figure 8: Male life expectancy, East Sussex districts and boroughs, 1991–1993 to 2006–2008



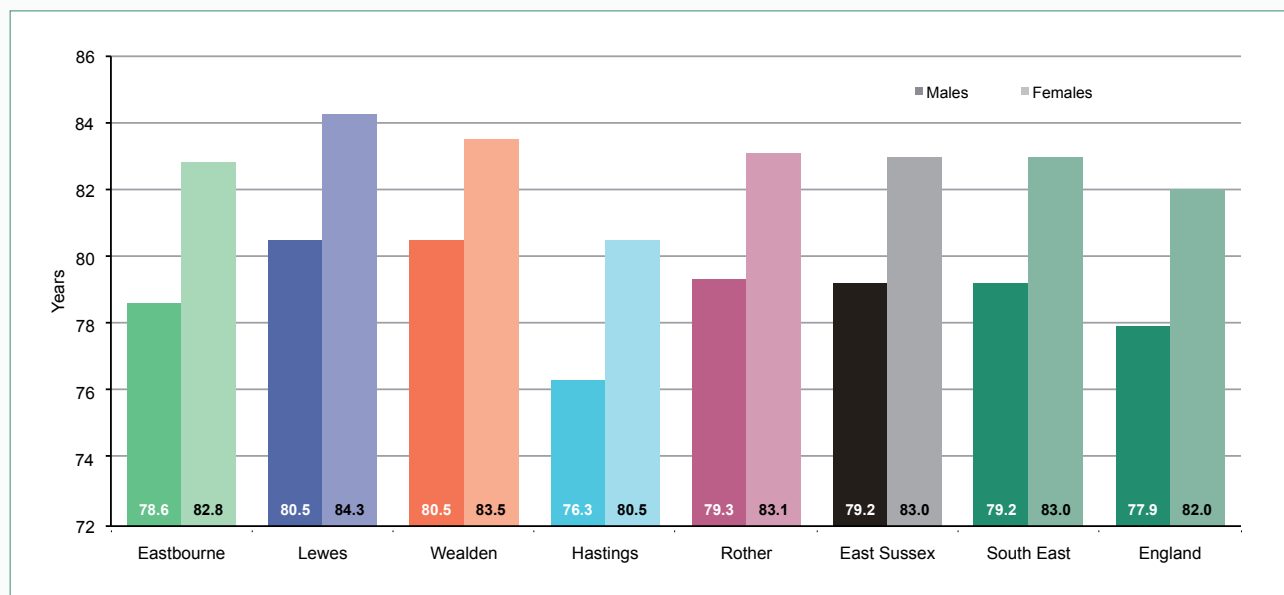
Source: Compendium of Clinical and Health Indicators

Figure 9: Female life expectancy, East Sussex districts and boroughs, 1991–1993 to 2006–2008



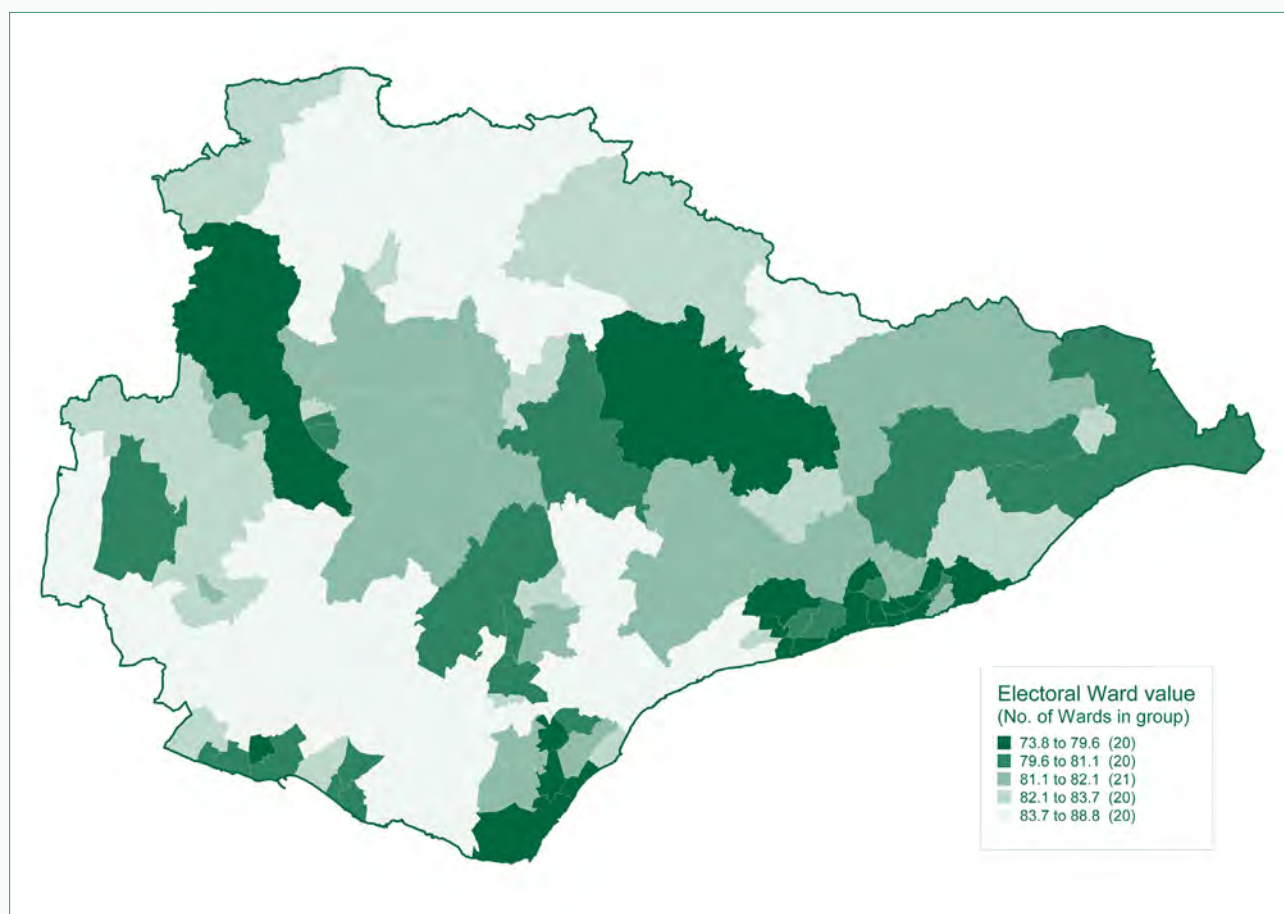
Source: Compendium of Clinical and Health Indicators

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



Source: Compendium of Clinical and Health Indicators

Figure 11: Life expectancy at birth, East Sussex electoral wards, 2005–2007



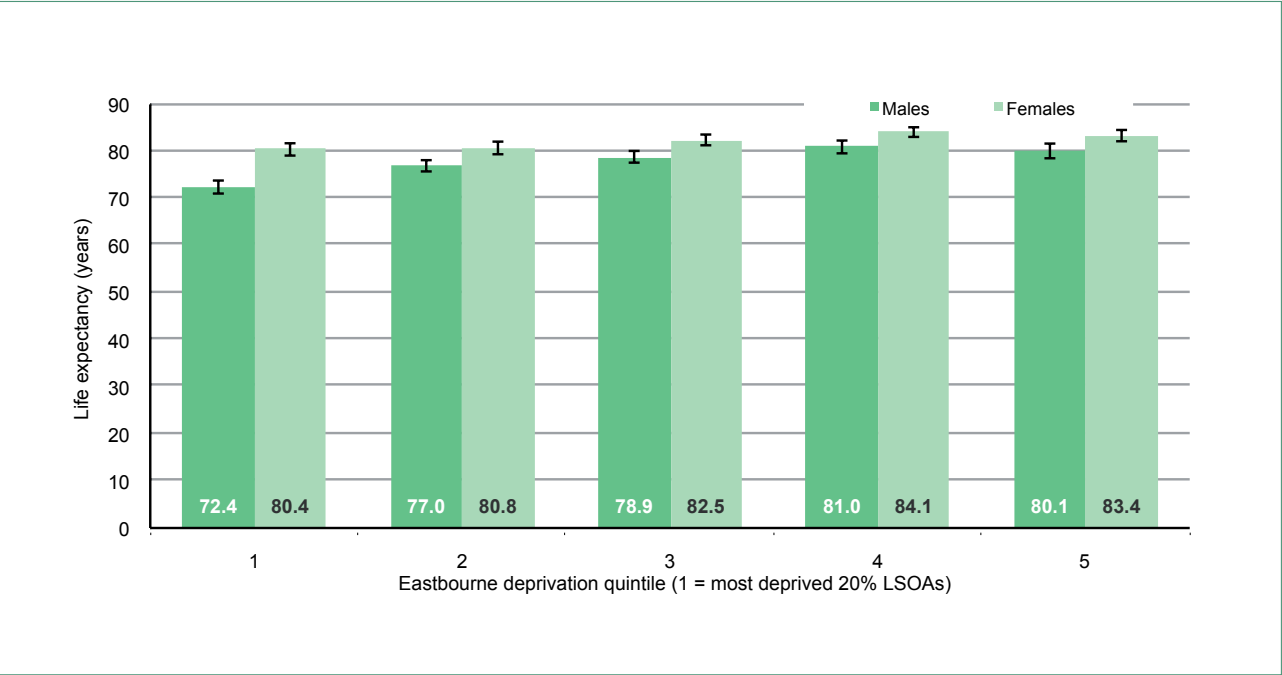
Source: ONS mortality data

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The following figures are taken from the Association of Public Health Observatories Health Profiles (www.healthprofiles.info).

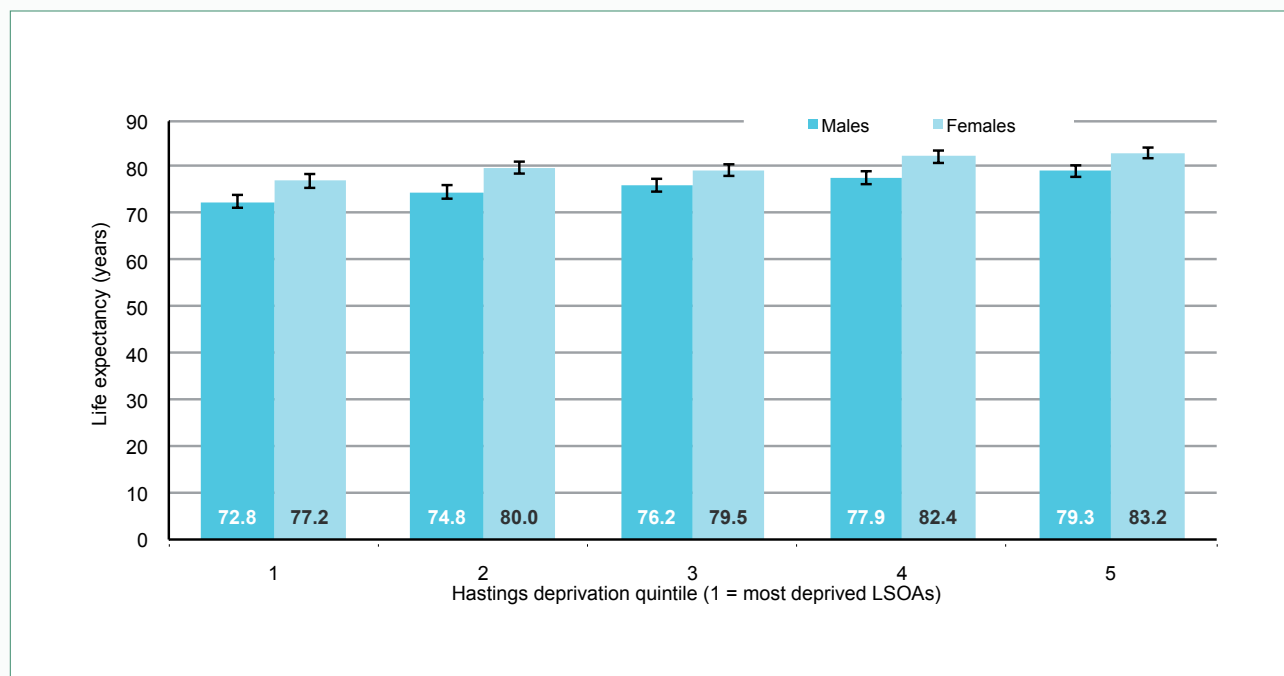
They show life expectancy at birth for males and females (2004–2008) for each of the deprivation quintiles in each area (where 1 is the least deprived and 5 is the most deprived).

Figure 12: *Life expectancy at birth by deprivation quintile with 95% confidence intervals, Eastbourne, 2004–2008*



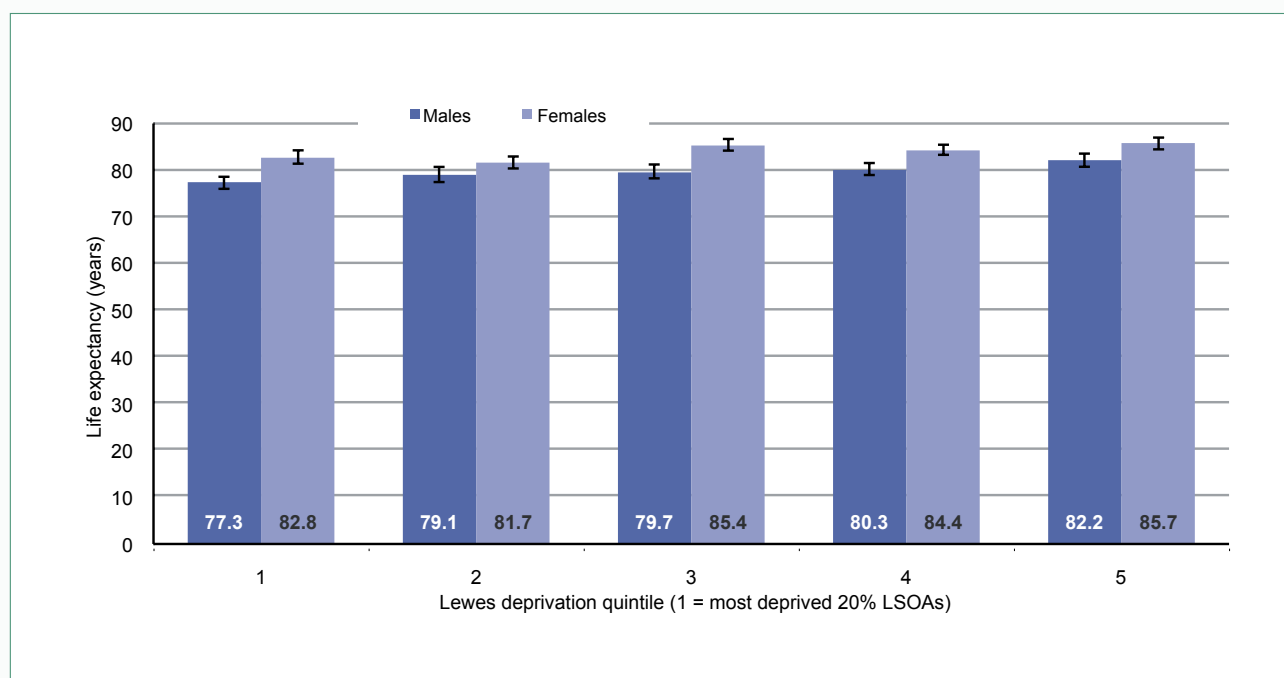
Source: APHO health profiles

Figure 13: *Life expectancy at birth by deprivation quintile with 95% confidence intervals, Hastings, 2004–2008*



Source: APHO health profiles

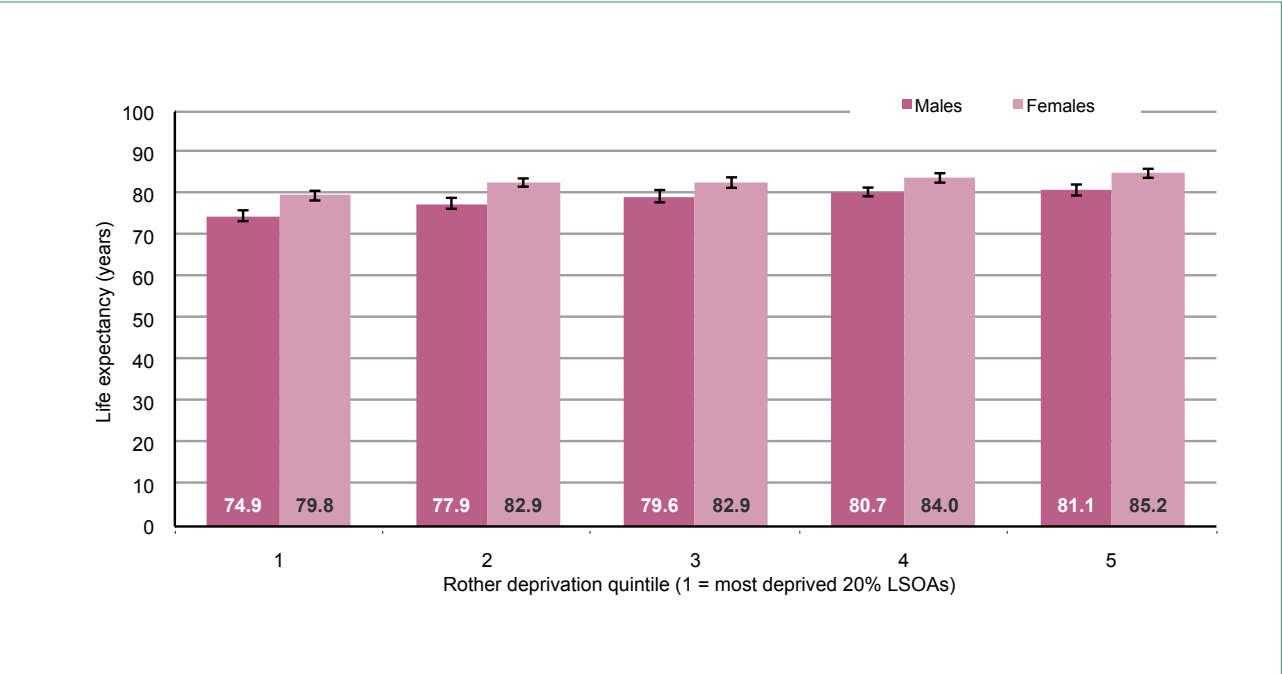
Figure 14: *Life expectancy at birth by deprivation quintile with 95% confidence intervals, Lewes, 2004–2008*



Source: APHO health profiles

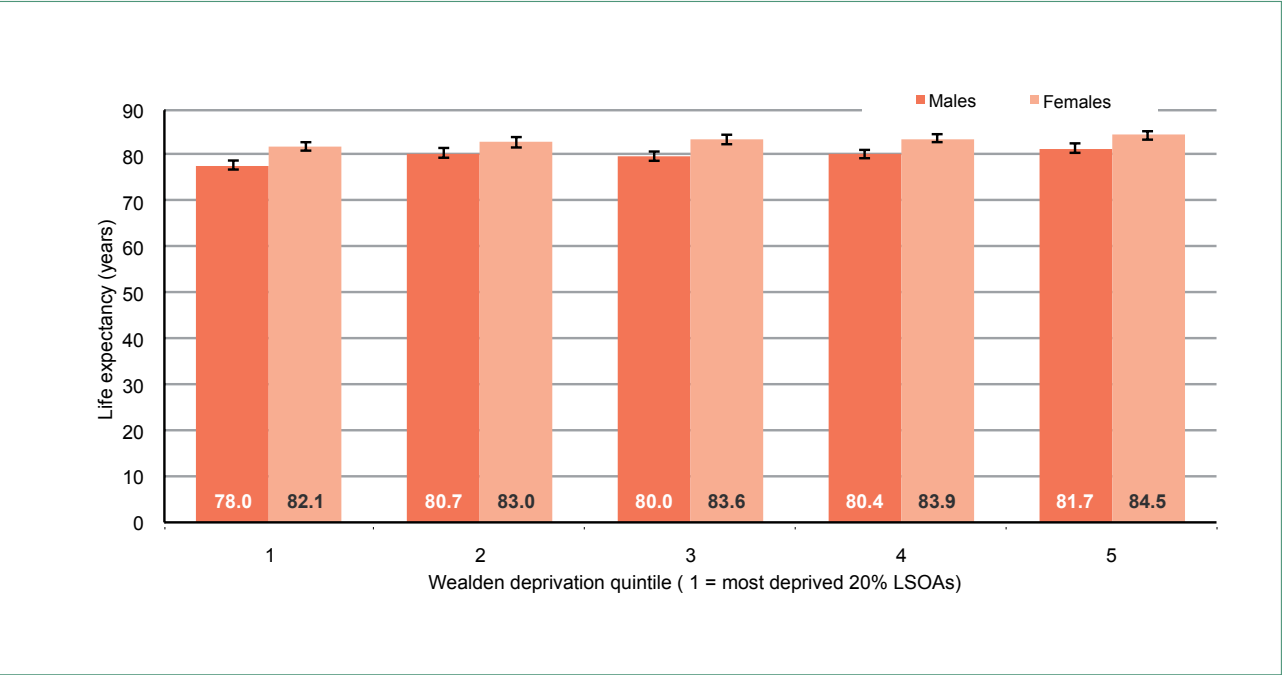
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Figure 15: Life expectancy at birth by deprivation quintile with 95% confidence intervals, Rother, 2004–2008



Source: APHO health profiles

Figure 16: Life expectancy at birth by deprivation quintile with 95% confidence intervals, Wealden, 2004–2008



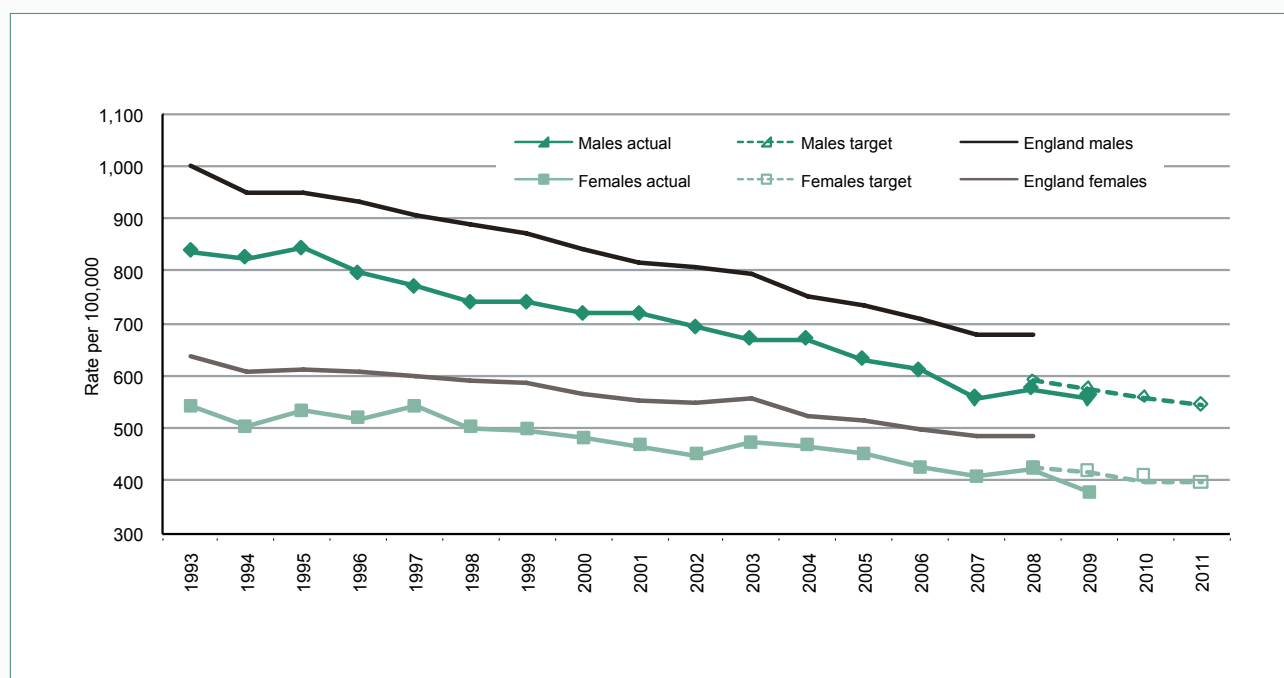
Source: APHO health profiles

All age all cause mortality

All age, all cause mortality rates continue to decrease in line with national and regional trends. There was a slight increase in NHS East Sussex Downs and Weald in 2008, but the PCT came in on target.

At ward level there is wide variation, ranging from a standardised mortality ratio of 188 in Maze Hill (Hastings) to 58 in Crowborough Jarvis Brook (Wealden). Some of the areas with smaller populations and smaller numbers of deaths are sometimes influenced by the location of nursing and care homes.

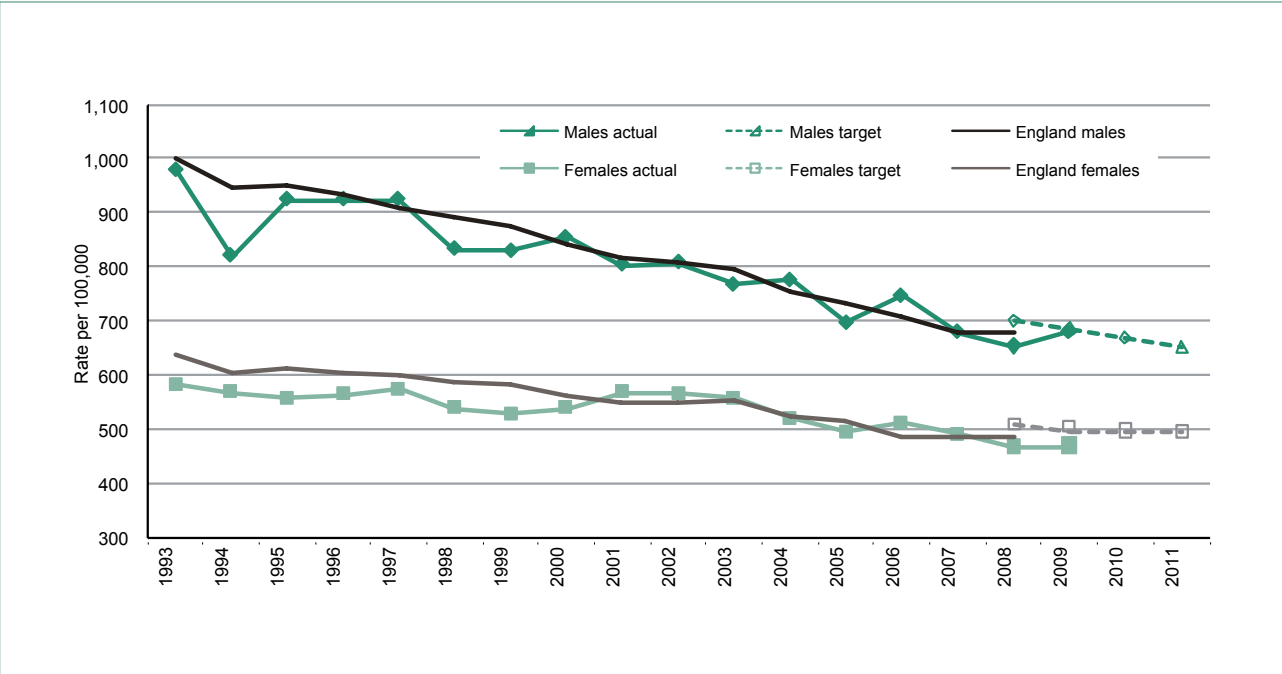
Figure 17: All age, all cause mortality, NHS East Sussex Downs and Weald, 1993–2008 (directly age-standardised rate per 100,000 population)



Source: ONS mortality data and PCT LDP and Vital Sign plans

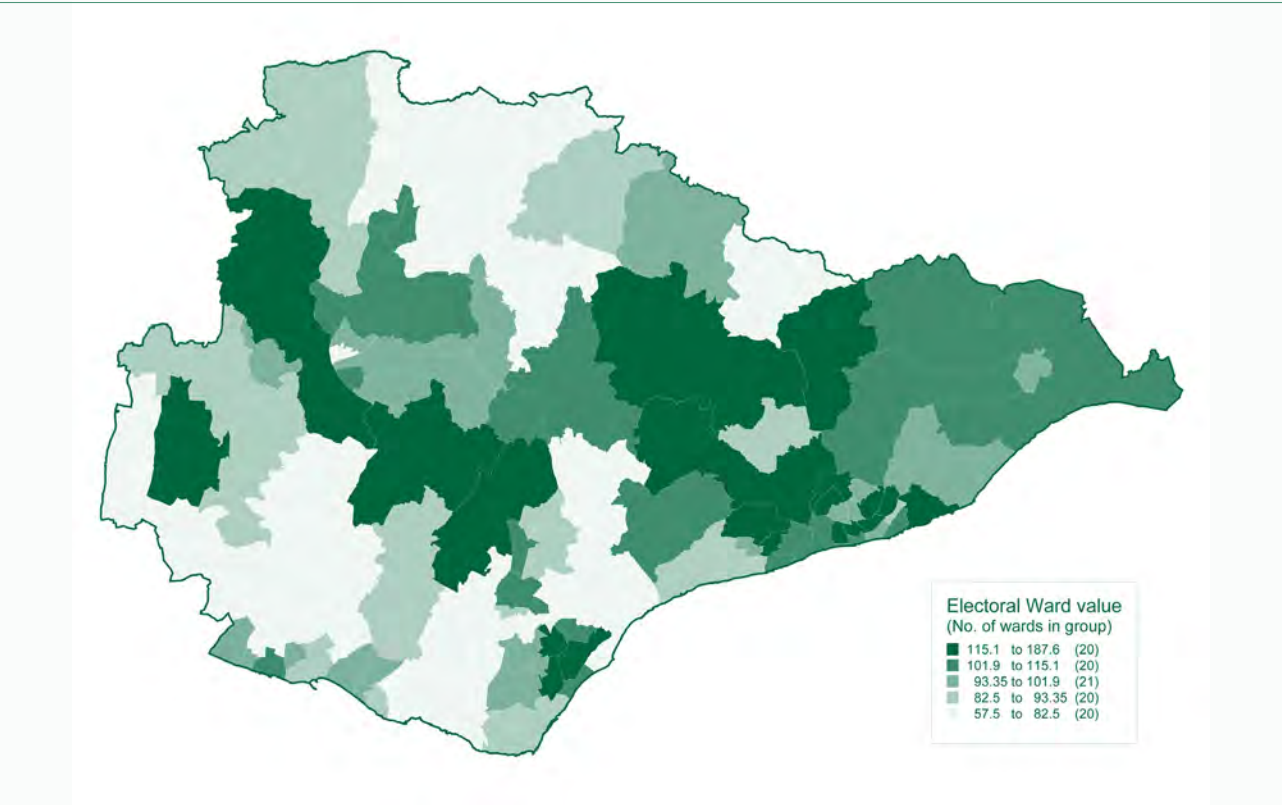
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Figure 18: All age, all cause mortality, NHS Hastings and Rother, 1993–2008 (directly age-standardised rate per 100,000 population)



Source: ONS mortality data and PCT LDP and Vital Sign plans

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



Source: ONS mortality data

Slope Index of Inequality

The IMD indicator has been criticised for a number of reasons, the consequence of which is that the Association of Public Health Observatories (APHO) has developed a new, more meaningful indicator.⁷

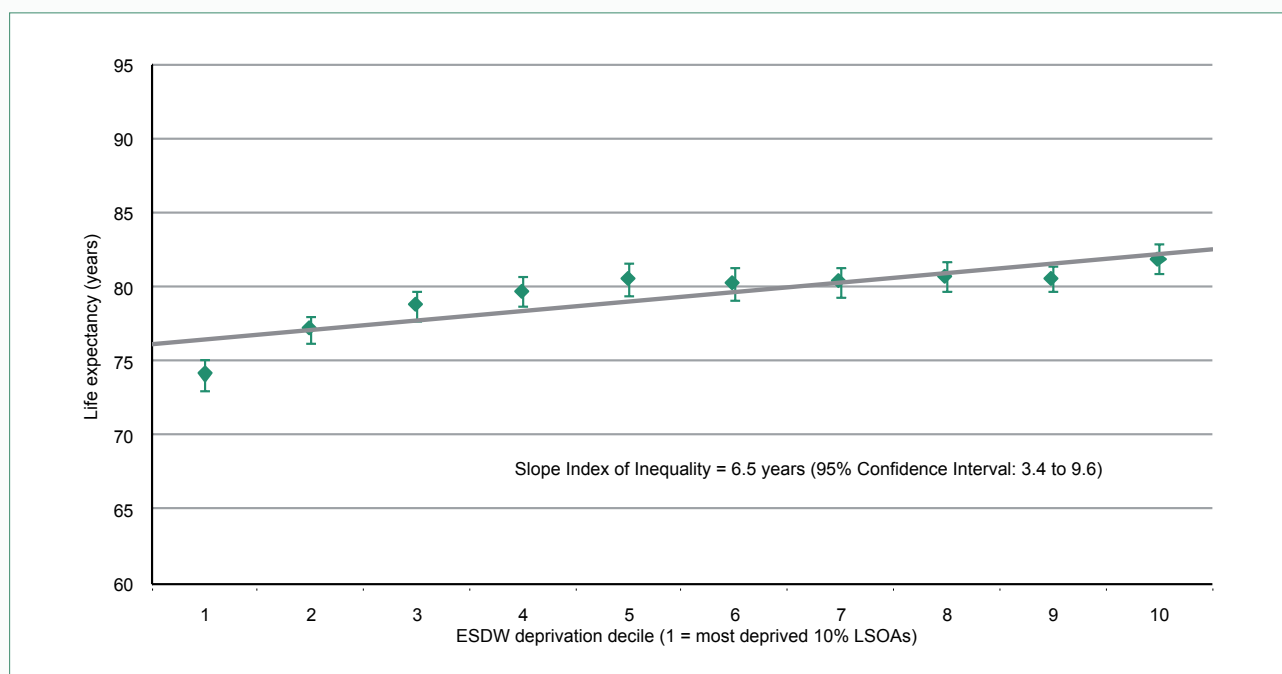
The new inequalities indicator is the Slope Index of Inequality (SII) for life expectancy at birth, calculated by grouping LSOAs within each PCT into deciles based on the IMD score of each LSOA. This represents the gap in years of life expectancy between the most and least deprived within the PCT, split for males and females.

For each deprivation decile, the life expectancy and 95% confidence intervals (CIs) are calculated, and the SII is the difference between the top of the line (at 100%) and the bottom of the line (at 0%) – see NHS East Sussex Downs and Weald SII in Figures 20 and 21. Table 5 shows the corresponding data and populations in each decile.

In NHS East Sussex Downs and Weald, there is an SII of 6.5 years in males and 4.2 years in females. This is different from calculating the gap between the most deprived and least deprived deciles (7.8 years in males and 3.5 years in females from data in Table 5, overleaf).

In NHS Hastings and Rother, there is an SII of 9.5 years in males and 7.5 years in females. This is different from calculating the gap between the most deprived and least deprived deciles (8.9 years in males and 7.9 years in females from data in Table 6, overleaf).

Figure 20: *Life expectancy at birth by deprivation deciles, showing the SII, NHS East Sussex Downs and Weald, males, 2004–2008*

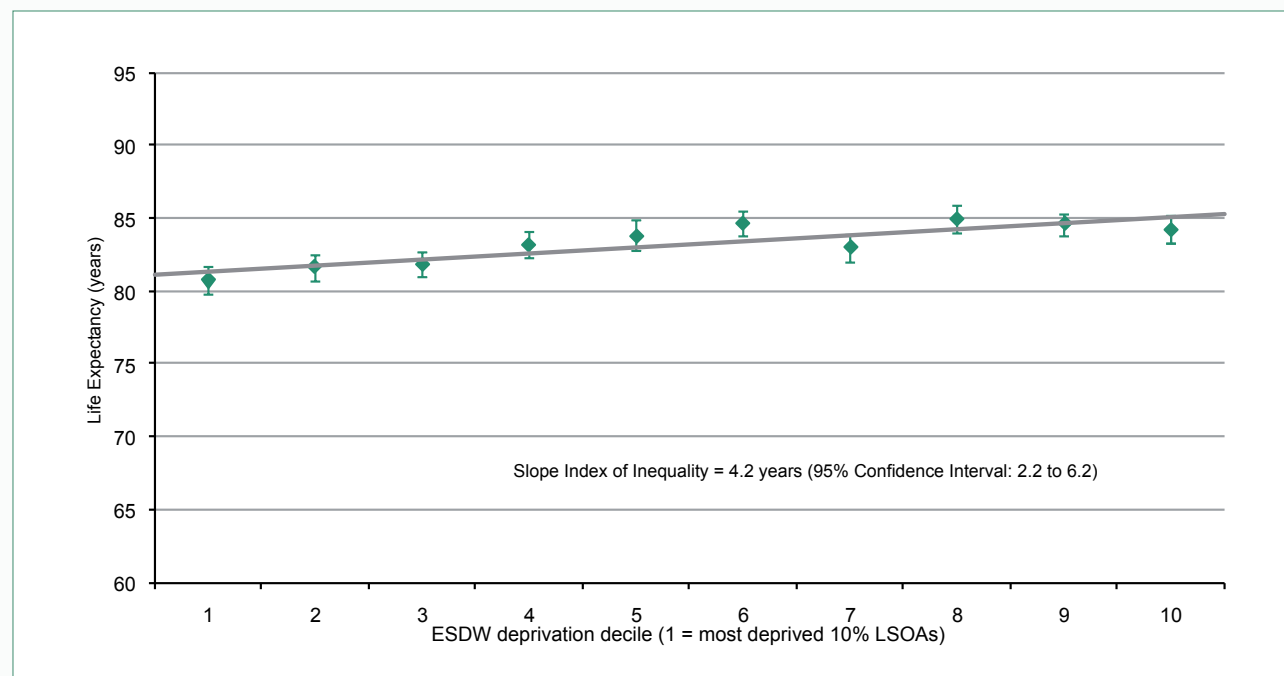


Source: Association of Public Health Observatories

⁷ *World Class Commissioning Assurance Framework: Recommendations for a Health Inequalities Indicator*. APHO, August 2009. Available from: <http://www.apho.org.uk/resource/view.aspx?RID=75050>

1 / What's Important about Health Inequalities?

Figure 21: Life expectancy at birth by deprivation deciles, showing the SII, NHS East Sussex Downs and Weald, females, 2004–2008



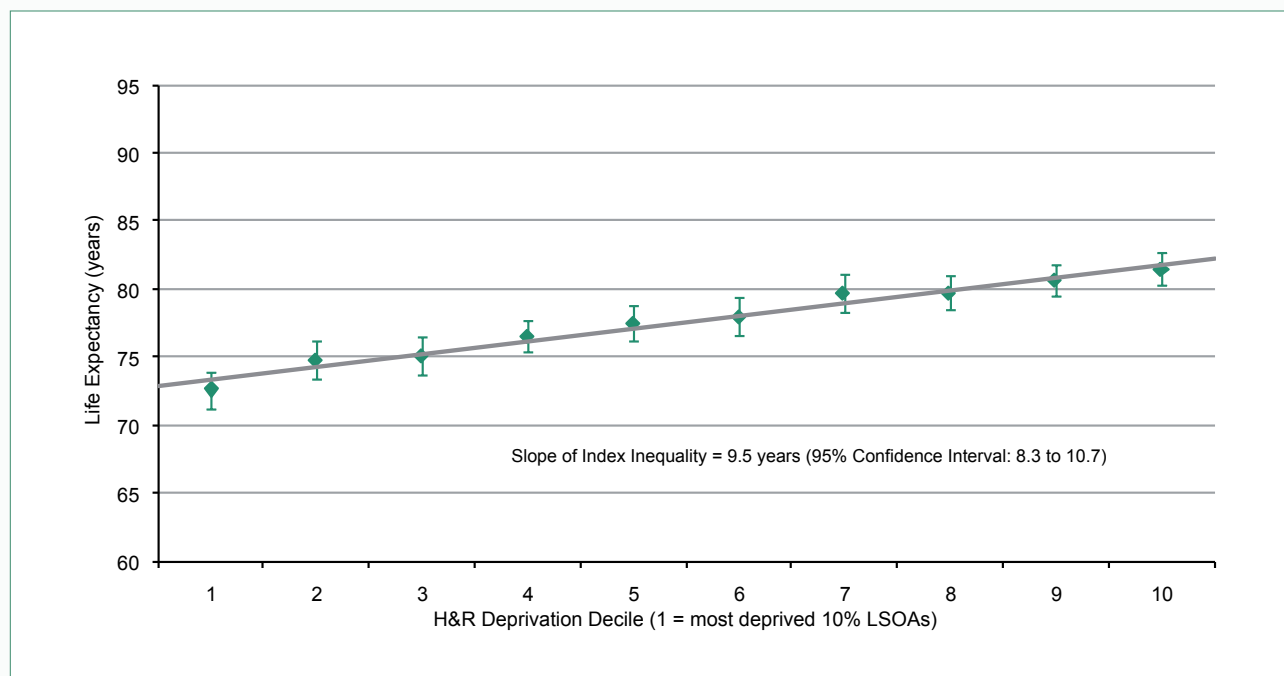
Source: Association of Public Health Observatories

Table 5: Life expectancy by deprivation deciles, males and females, 2004–2008, NHS East Sussex Downs and Weald

Decile	Male			Female		
	Life expectancy	95% CI	Population	Life expectancy	95% CI	Population
1	74.1	{73.0, 75.1}	16,372	80.7	{79.8, 81.7}	18,207
2	77.1	{76.2, 78.0}	15,670	81.6	{80.7, 82.5}	17,697
3	78.7	{77.7, 79.7}	16,019	81.8	{81.0, 82.7}	17,316
4	79.7	{78.7, 80.7}	15,007	83.2	{82.3, 84.1}	16,742
5	80.5	{79.4, 81.6}	15,276	83.8	{82.8, 84.9}	16,889
6	80.2	{79.1, 81.3}	15,896	84.6	{83.8, 85.5}	17,275
7	80.3	{79.3, 81.3}	15,584	83.0	{82.0, 83.9}	16,849
8	80.7	{79.7, 81.7}	16,206	85.0	{84.0, 85.9}	17,483
9	80.5	{79.7, 81.4}	16,217	84.6	{83.8, 85.3}	18,045
10	81.9	{80.9, 82.9}	15,135	84.2	{83.3, 85.2}	16,175

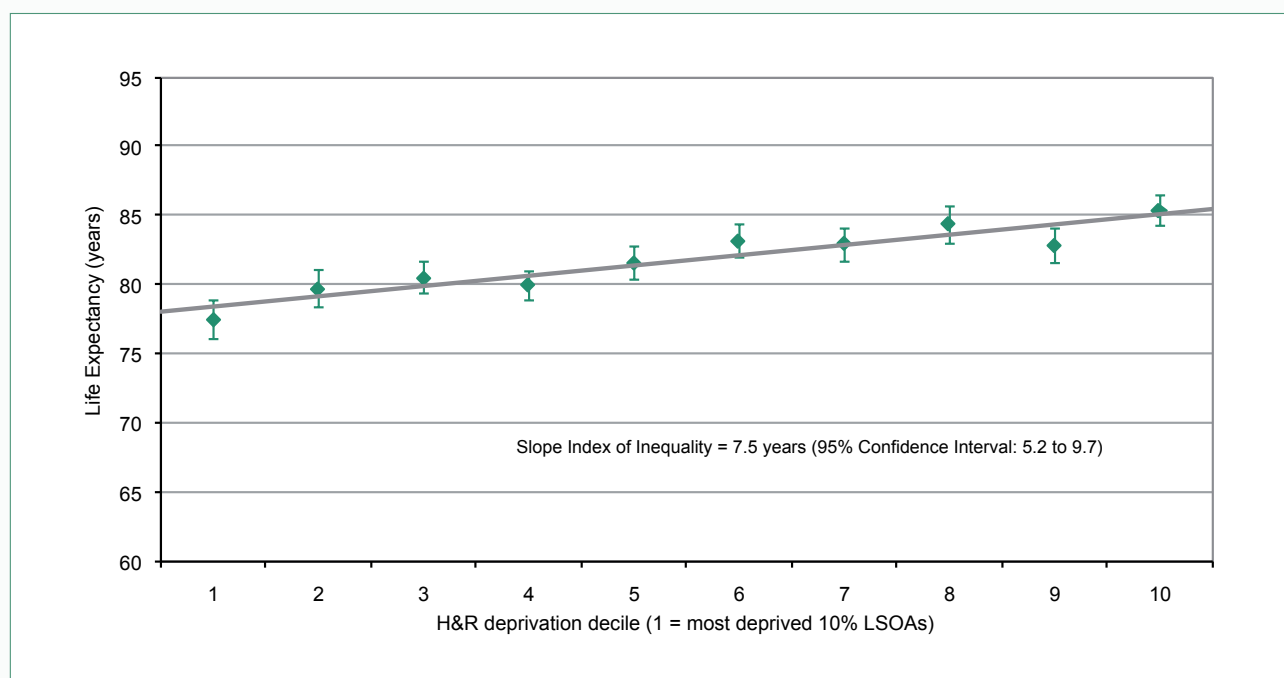
Note: Decile 1 is the most deprived decile. Population refers to the average of the mid-year population estimates for 2004–08. Sources: ONS death registration data and mid-year population estimates & Department of Communities and Local Government, Indices of Deprivation 2007. Analysis carried out by LHO and EMPHO on behalf of APHO.

Figure 22: Life expectancy at birth by deprivation deciles, showing the SII, NHS Hastings and Rother, males, 2004–2008



Source: Association of Public Health Observatories

Figure 23: Life expectancy at birth by deprivation deciles, showing the SII, NHS Hastings and Rother, females, 2004–2008



Source: Association of Public Health Observatories

1 / What's Important about Health Inequalities?

Table 6: Life expectancy by deprivation deciles, males and females, 2004–2008, NHS Hastings and Rother

Decile	Male			Female		
	Life expectancy	95% CI	Population	Life Expectancy	95% CI	Population
1	72.6	{71.2, 73.9}	9,211	77.5	{76.1, 78.9}	9,714
2	74.8	{73.4, 76.2}	8,103	79.7	{78.4, 81.1}	8,999
3	75.1	{73.7, 76.5}	8,154	80.5	{79.4, 81.7}	9,036
4	76.5	{75.4, 77.7}	9,210	80.0	{78.9, 81.0}	10,134
5	77.5	{76.2, 78.8}	7,925	81.6	{80.4, 82.8}	8,707
6	78.0	{76.6, 79.4}	8,034	83.2	{82.0, 84.4}	8,794
7	79.7	{78.3, 81.1}	9,214	82.9	{81.7, 84.1}	9,998
8	79.7	{78.5, 81.0}	7,506	84.4	{83.0, 85.7}	8,369
9	80.7	{79.5, 81.8}	8,311	82.8	{81.6, 84.1}	9,201
10	81.5	{80.3, 82.7}	8,583	85.4	{84.3, 86.5}	9,216

Note: Decile 1 is the most deprived decile. Population refers to the average of the mid-year population estimates for 2004–08. Sources: ONS death registration data and mid-year population estimates & Department of Communities and Local Government, Indices of Deprivation 2007. Analysis carried out by LHO and EMPHO on behalf of APHO.

Table 7: Rank out of 152 PCTs (1 is the worse/largest inequality gap)

	Males	Females
NHS East Sussex Downs and Weald	123	119
NHS Hastings and Rother	58	32

The APHO states that the SII indicator is suitable for comparison between PCTs. Although small differences between PCTs index scores will not be statistically significant, those between PCTs near the top and bottom of ranked tables will be.

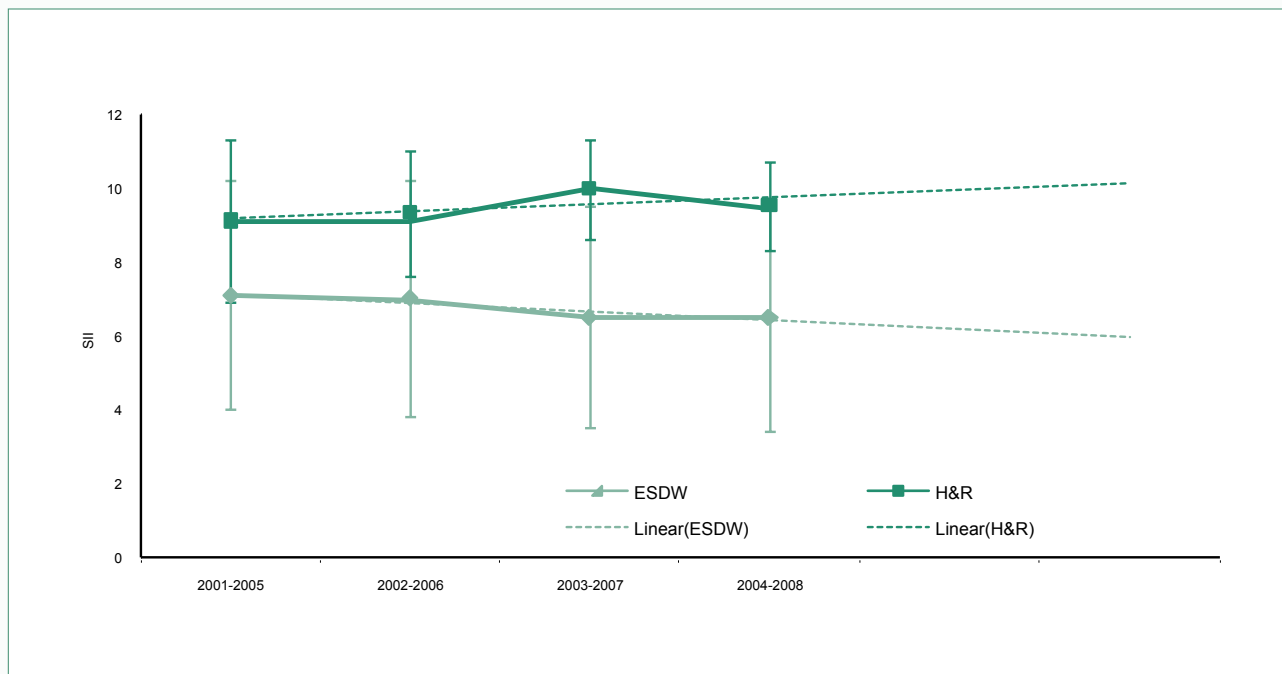
There are no significant differences for either NHS East Sussex Downs and Weald or NHS Hastings and Rother SII scores for 2004–2008 compared to the median in England.

The indicator uses five year pooled data to enable robust calculation. This means that the SII is less up-to-date and responsive in the short-term. However, it minimises random fluctuation. The APHO suggest that changes in the SII can realistically be expected to be measured if assessed within five to ten years.

Data have been made available for 2001–2005 up to 2004–2008 and will be updated annually.

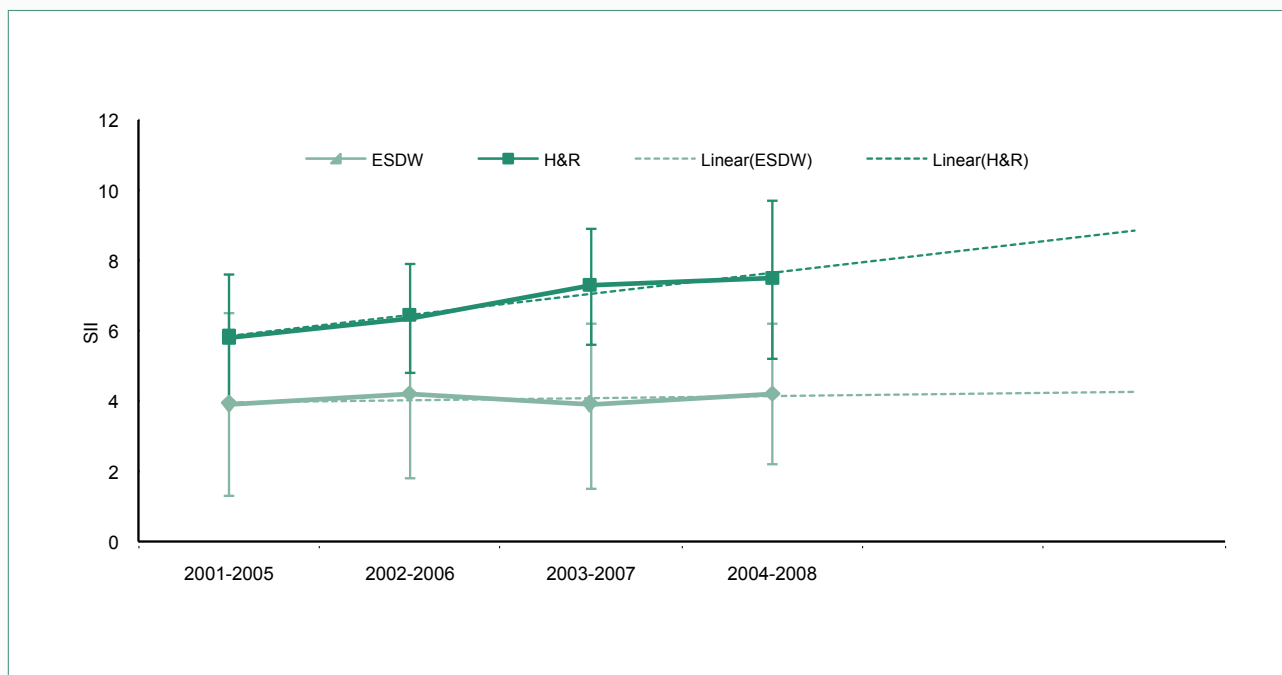
The trend in the SII is presented in Figures 24 (males) and 25 (females). For NHS East Sussex Downs and Weald, the gap in life expectancy in males is narrowing slightly (shown by a downward trend) but appears to be fairly constant in females between the most and least deprived. In NHS Hastings and Rother, the gap in life expectancy in both males and females between the most and least deprived is projected to widen (SII upward trend), more so in females than males.

Figure 24: *PCT SII (gap in life expectancy) with 95% confidence intervals, males, 2001–2005 to 2004–2008*



Source: Association of Public Health Observatories

Figure 25: *PCT SII (gap in life expectancy) with 95% confidence intervals, females, 2001–2005 to 2004–2008*



Source: Association of Public Health Observatories

Vital Signs targets

Vital Signs are the targets set for PCTs nationally that measure performance against plans to address selected health priorities derived from the Operating Framework for the NHS 2010/11.

The cancer and CVD national targets are:

- 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, and
- 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.

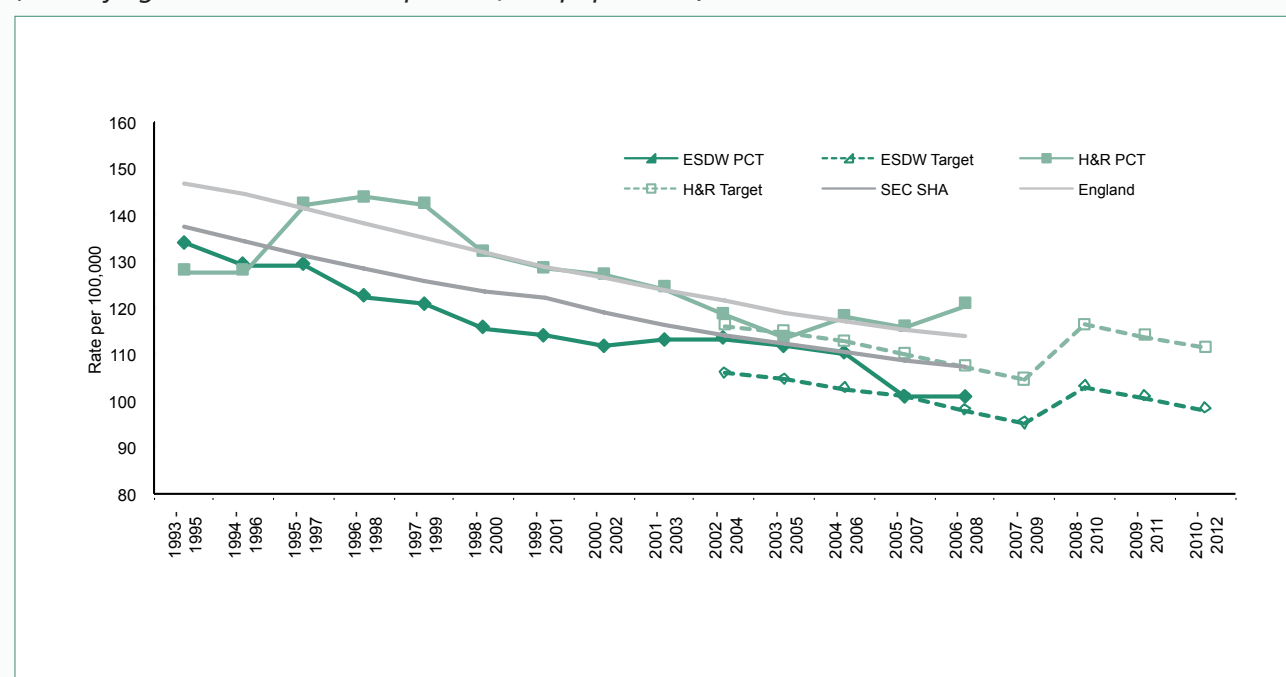
Cancer mortality

Both NHS East Sussex Downs and Weald and NHS Hastings and Rother missed their vital signs targets for cancer mortality among people aged under 75 years for the period 2006–2008. Within NHS East Sussex Downs and Weald, the rate remained the same as the previous period, having seen a decline for the preceding four periods. The rate remains below that for England and the South East region. Within NHS Hastings and Rother, the rate increased above that for England as a whole and substantially higher than the target. The maps in Chapter 4 show cancer mortality and prevalence from GP records.

Premature deaths from all circulatory diseases

Both PCTs continue to show good progress against targets for deaths from all circulatory diseases for persons aged under 75 years. This covers deaths from CHD, heart attacks and strokes. NHS Hastings and Rother is below the rate for England and NHS East Sussex Downs and Weald is below the regional and national rate.

Figure 26: All cancer mortality, all persons aged under 75 years, 1993–1995 to 2010–2012 (directly age-standardised rate per 100,000 population)



Source: ONS mortality data and PCT LDP and Vital Sign plans

At an electoral ward level for 2003–2007,
the higher death rates were around Hastings,

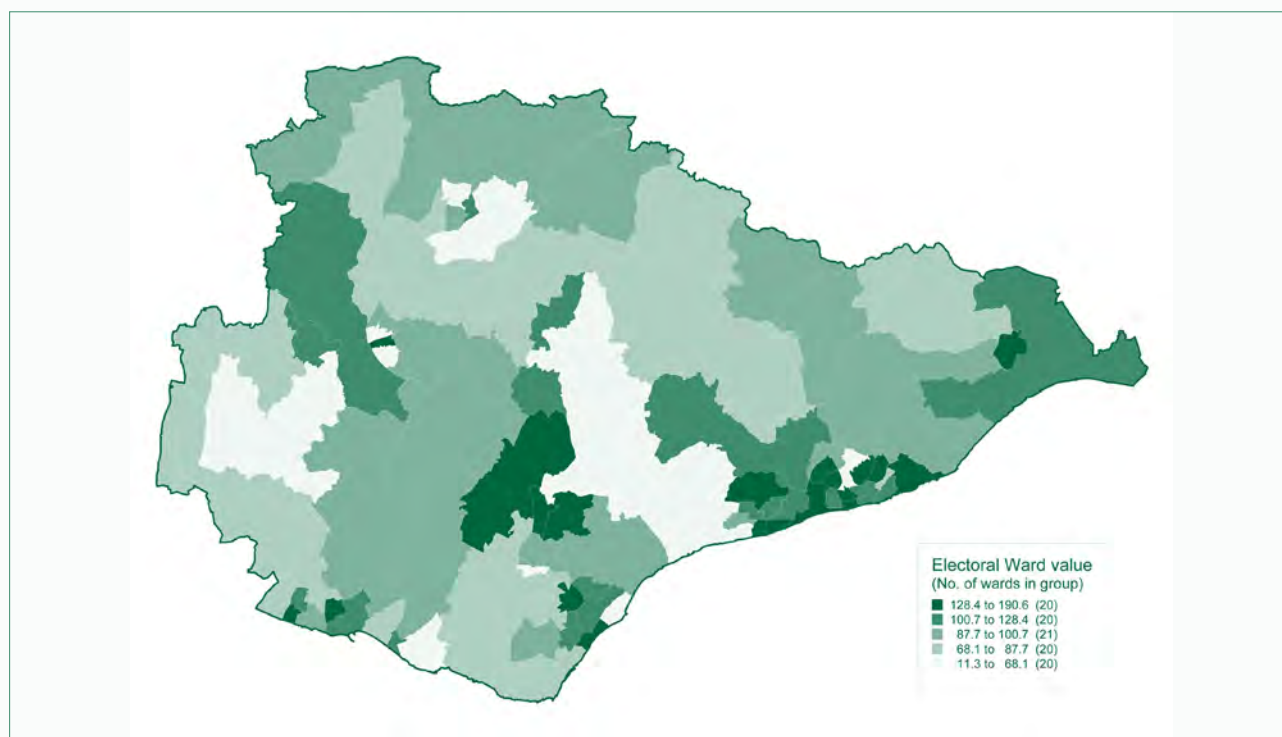
St Leonards, Bexhill, Eastbourne, Hailsham
and the Havens.

Figure 27: *All circulatory disease mortality, all persons aged under 75 years, 1993–1995 to 2010–2012 (directly age-standardised rate per 100,000 population)*



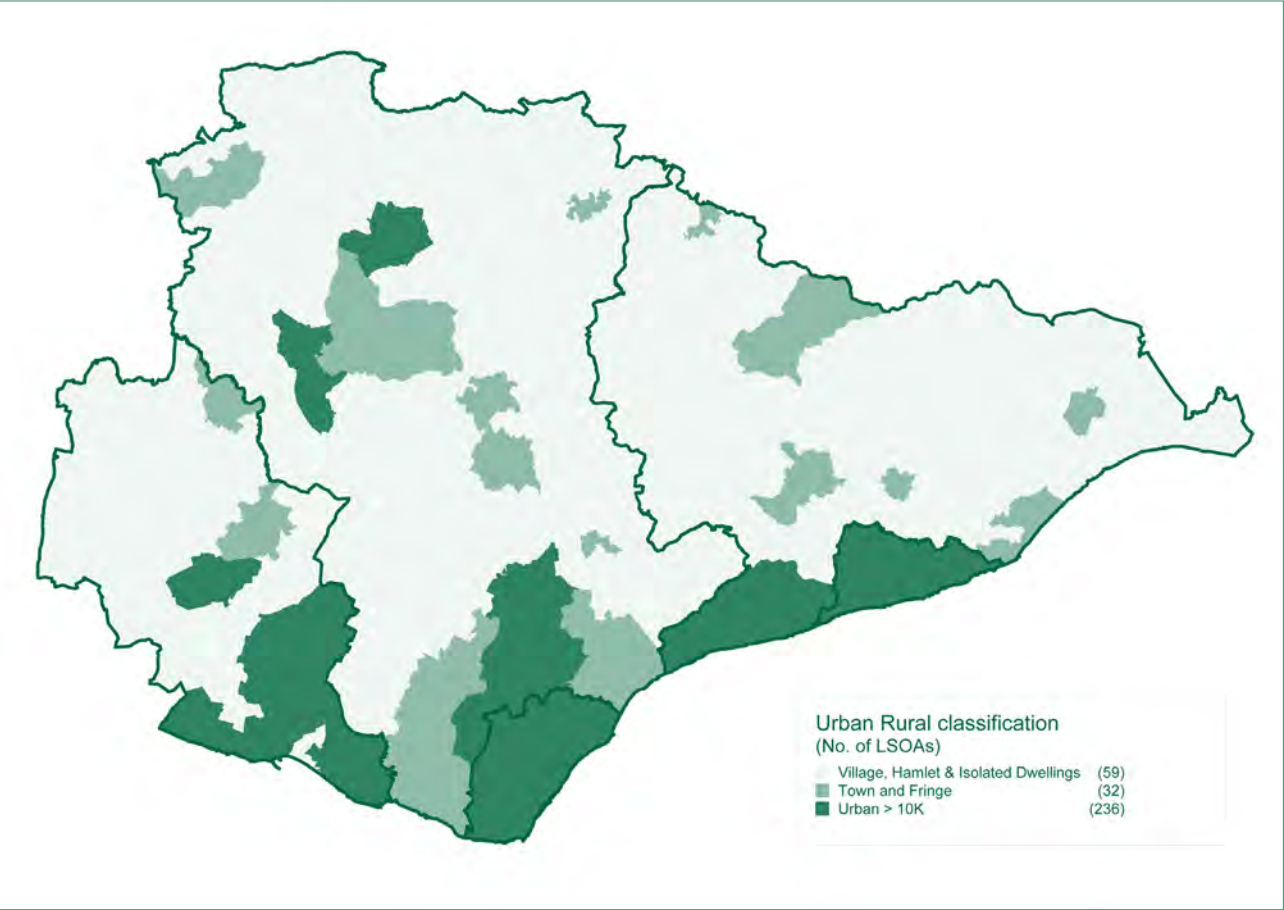
Source: ONS mortality data and PCT LDP and Vital Sign plans

Figure 28: *Standardised mortality ratios for deaths from all circulatory disease in persons aged under 75, East Sussex electoral wards, 2003–2007 (East Sussex = 100)*



Source: ONS mortality data

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



Source: ONS mortality data

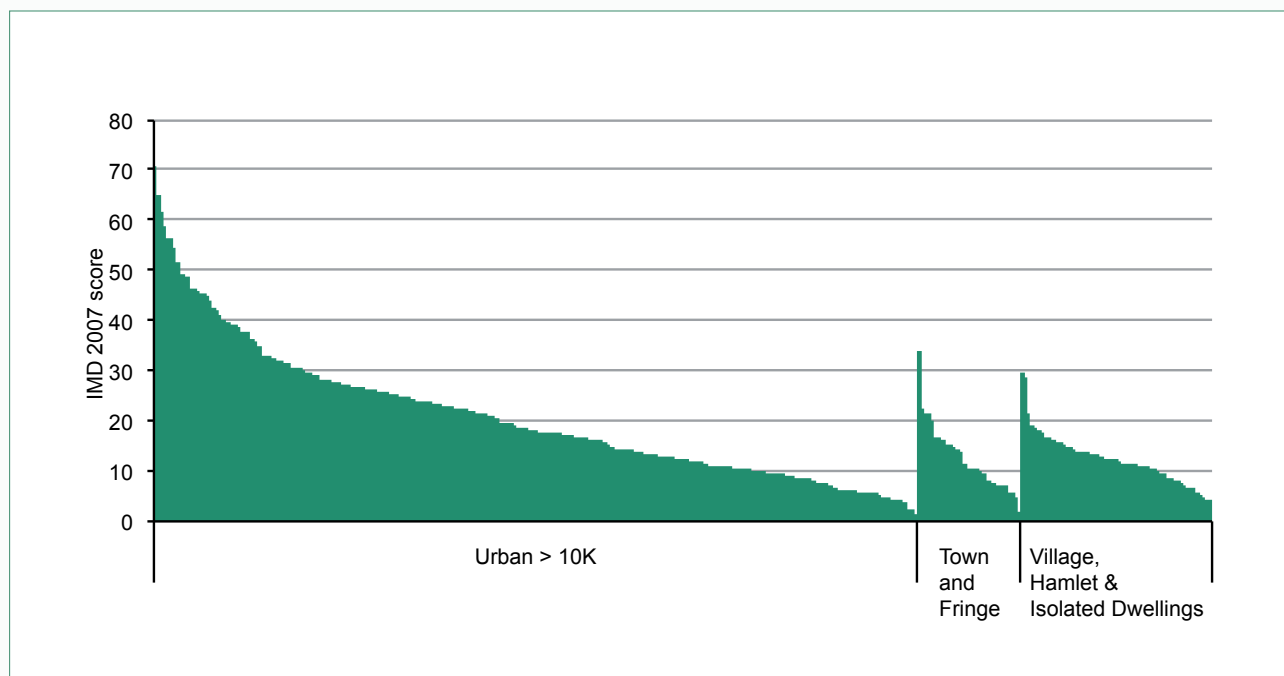
Rural/urban

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

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

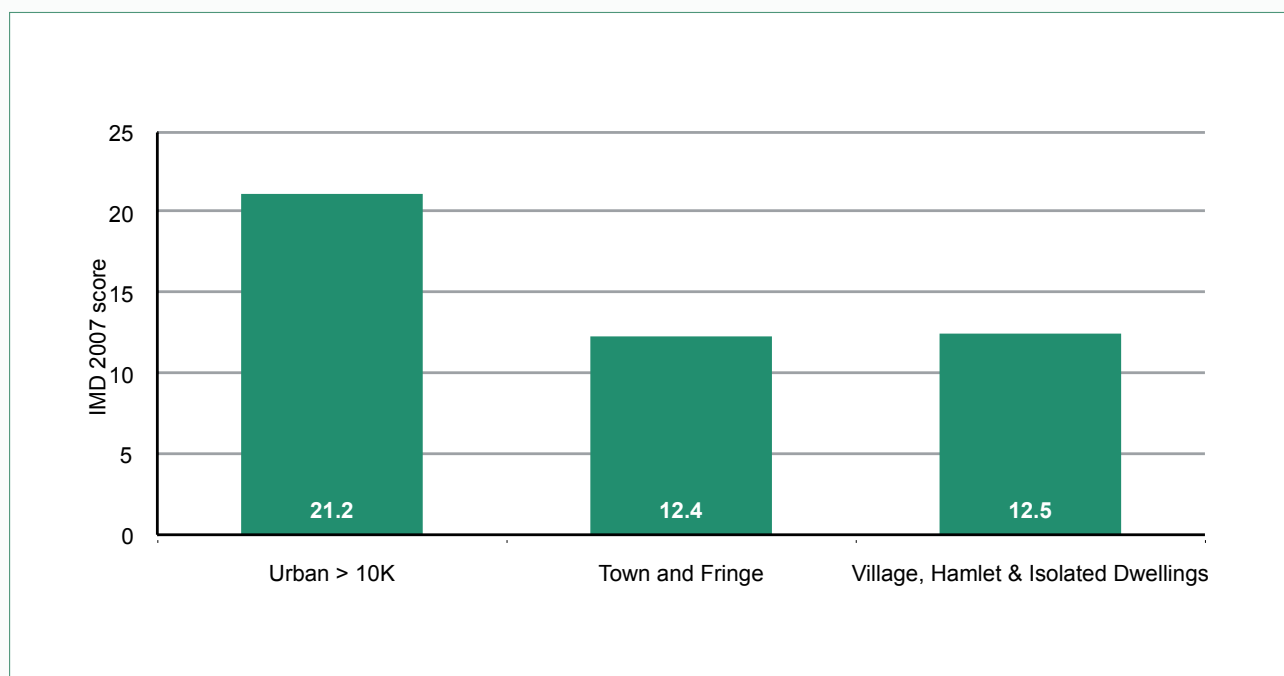
When you calculate overall deprivation scores for these areas, there is a clear difference between the ‘urban’ populations over 10,000 and the other two categories.

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



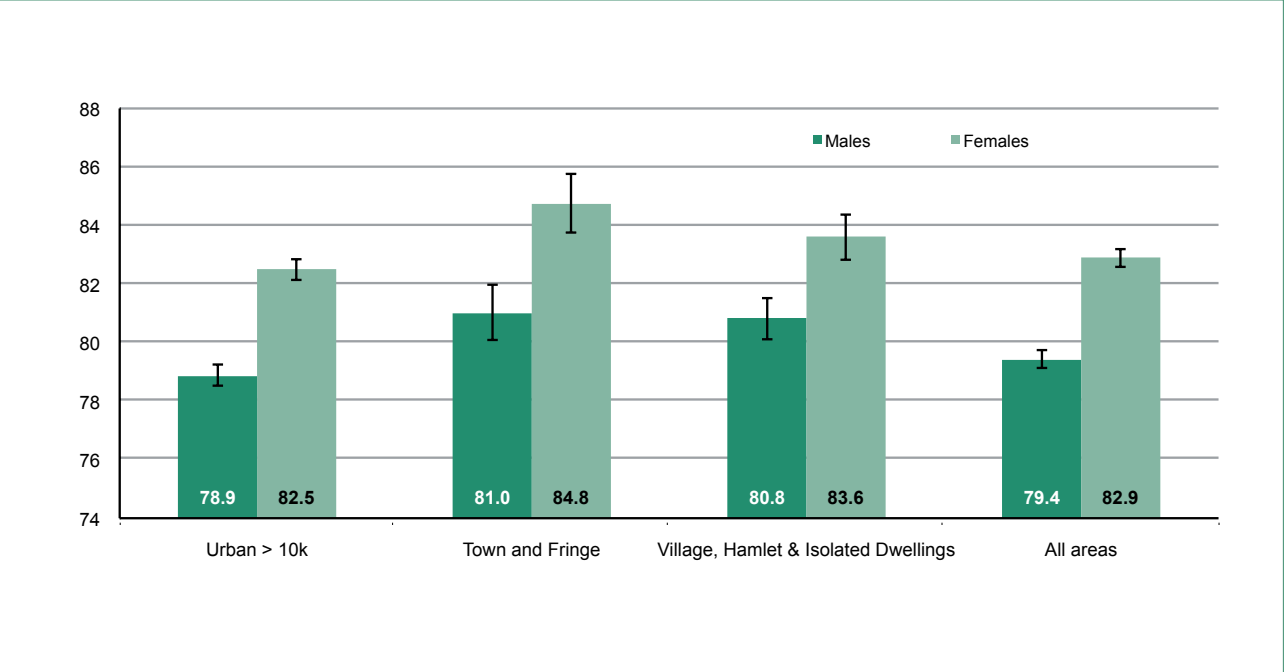
Source: IMD 2007 and Rural and Urban Classification 2004

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



Source: IMD 2007 and Rural and Urban Classification 2004

Figure 32: Life expectancy at birth with 95% confidence intervals, by urban / rural classification in East Sussex, 2006–2008



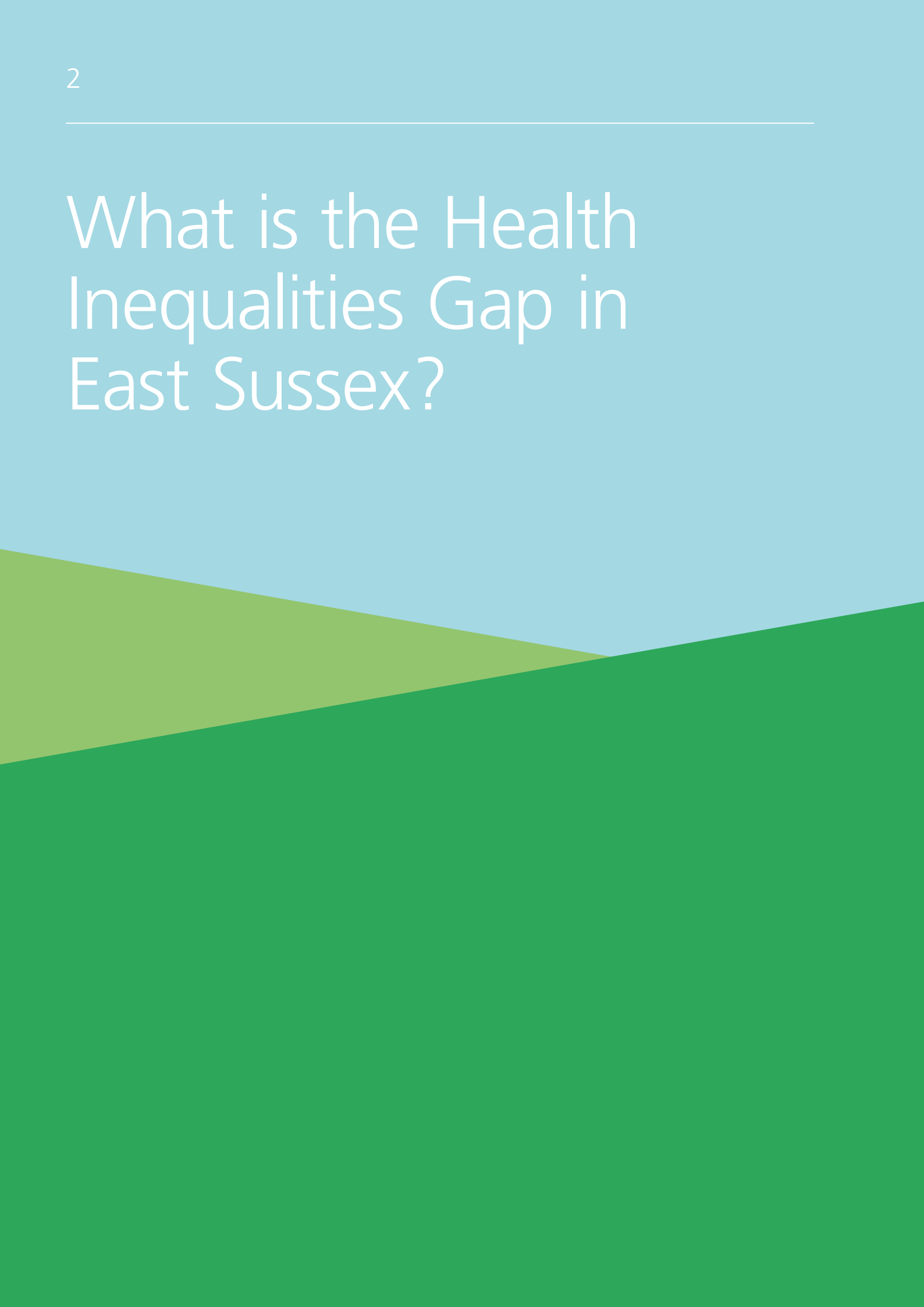
Source: ONS mortality data and PCT LDP and Vital Sign plans

Calculating life expectancy for each area of classification, it shows that the population in urban areas averaged 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 stylized landscape. The lower half is composed of two overlapping green shapes representing hills, with a darker green in the foreground and a lighter green behind it. The upper half is a solid light blue, representing the sky. The title text is positioned in the upper left area of the light blue section.

Main Contributors to Life Expectancy Gap

The London Health Observatory (LHO) has developed a health inequalities intervention tool that allows analysis of life expectancy gaps. The contribution of different diseases to the gap can be identified and can therefore help indicate which interventions may be most appropriate in reducing the gap.

The LHO tool uses 2001–2005 data at a district and borough level and provides a breakdown of the main contributors to the life expectancy gap between the most and least income-deprived quintiles within each area. It can provide a valuable insight as to the nature of the gap in life expectancy within areas in East Sussex. The income deprivation indicator used to break the populations into quintiles is the percentage of residents dependent on means-tested benefits (2003).

A breakdown of the gap is presented as a ‘scarf chart’. These charts show the percentage contribution of various causes of death. The stripes of the scarf do not include the same number of people. Deaths in younger people, especially in babies, contribute to a larger proportion of the gap, as more years of life are lost.

For example, Figure 33 (page 47) shows the scarf chart for the main contributors to the gap in life expectancy between the most and least income-deprived in Eastbourne. It shows, for example, that deaths from respiratory diseases contribute to 12% of the life expectancy gap in males between the most and least deprived areas of Eastbourne, and 17% of the gap in females.

The LHO tool also produces life expectancy-gap analysis charts. These show the possible gain in life expectancy in income-deprived areas if, for specific causes, they experienced the same mortality rate as in the least income-deprived areas. For example, Figure 34 (page 48) shows the life expectancy-gap analysis chart for the gap between the most and least deprived in Eastbourne. It shows, for example, that, if males in the most deprived areas of Eastbourne had the same mortality rates for lung cancer as in the least deprived areas, the gain in life expectancy (in the most deprived areas) would be 0.6 years.

Scarf charts and gap-analysis charts are presented in this chapter for the gap in life expectancy between the most and least income-deprived quintiles within each East Sussex district/borough.

Another tool that helps to explain differences between the most and least deprived areas in East Sussex is the South East England Health Inequalities Gap Measurement Tool.

The tool provides cause-specific mortality rates for the five year period 2004–2008 and uses IMD 2007 to identify deprived quintiles. It identifies inequality gaps by comparing age-specific mortality rates between the most and least deprived areas of local authorities for specific causes of death. Building on the main contributors to the life expectancy gap, as identified using the LHO tool, analyses looking at age and cause-specific mortality rates for the main contributors have been carried out for each East Sussex district/borough. Although data have not been presented in graph format within this report, any differences in mortality between the most and least deprived areas within East Sussex will be discussed in the narrative. Age groups in which differences in mortality rates between the most and least deprived areas are statistically significant will be highlighted, that is, where we can be 95% confident that a true difference in the mortality rates between the areas exists.

2 / What is the Health Inequalities Gap in East Sussex?

Cause of death definitions used in life expectancy-gap analysis

Mortality from external causes includes, for example, transport accidents, falls and other external causes of accidental injuries.

‘Other’ is all other causes than those specified in the charts and will include things such as nervous system, mental and behavioural, perinatal conditions, endocrinal, metabolic and nutritional conditions, musculoskeletal diseases and congenital anomalies.

East Sussex

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

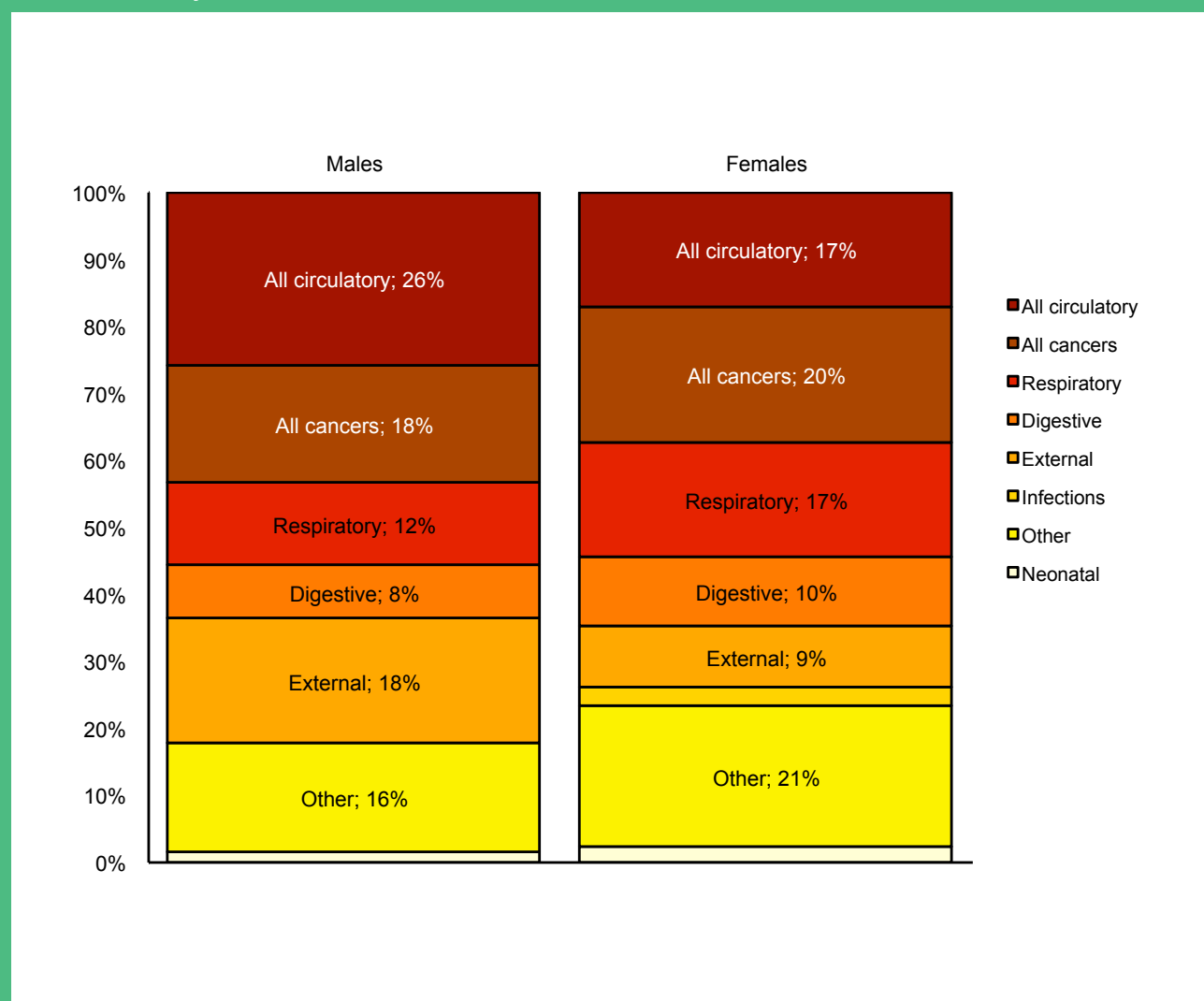
At a district/borough level, circulatory diseases are the largest contributor to the gap in life expectancy in three local authorities for males and females. Mortality from external causes is the largest contributor to the gap in males for two districts. Cancers are the largest contributor to the life 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 for ages 35–80 years, with significantly higher rates in people aged 45–79 years. Higher mortality rates from CHD can be seen across all ages, with significantly higher rates in those aged 45–49 and 55–79 years in the most deprived areas of East Sussex. 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 mortality significantly higher among those aged 50–54 years 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.

In 2001–2005, the life expectancy gap for males was 6.2 years and 0.7 years for females 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).

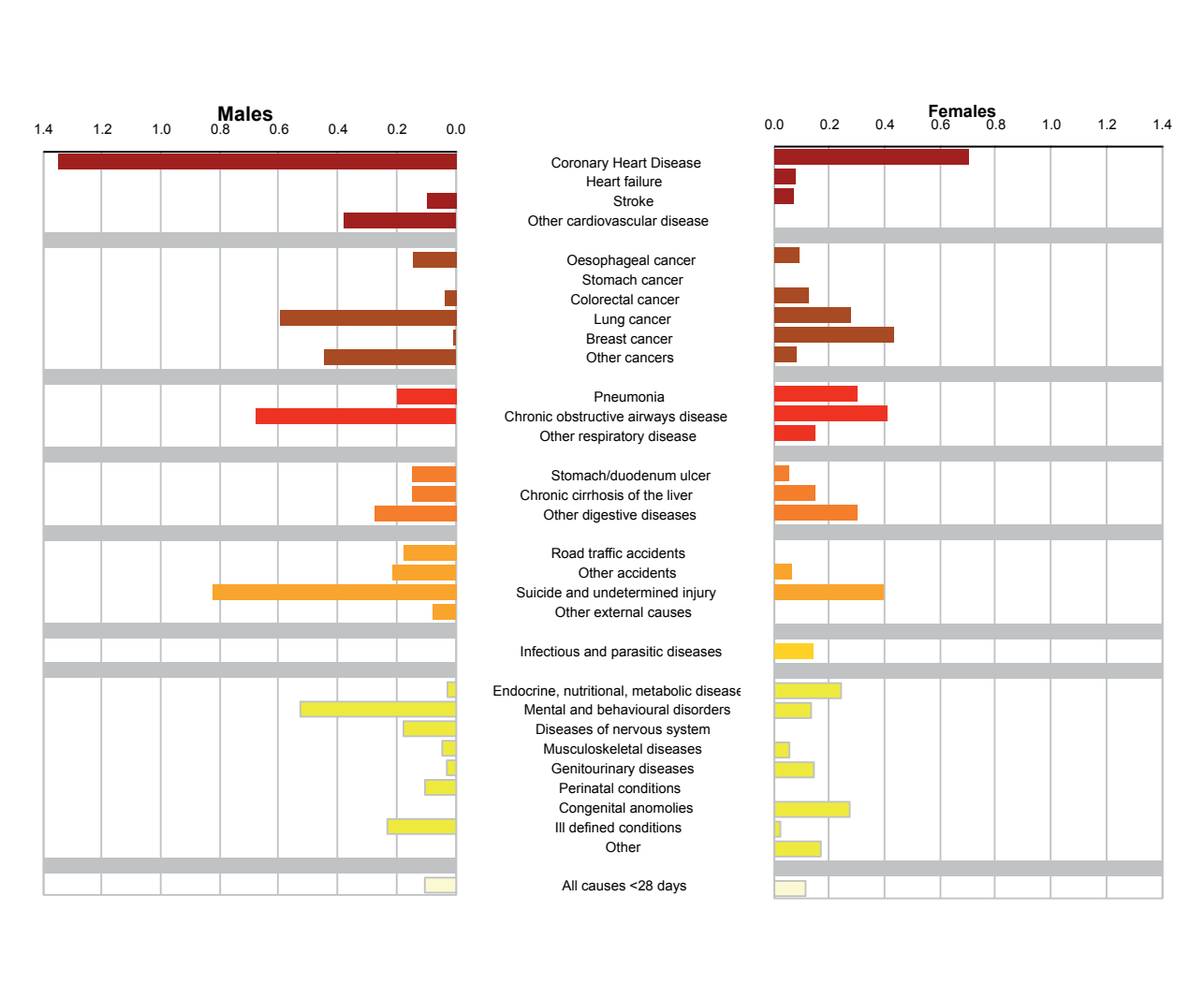
Further analysis of the gap in life expectancy (Figure 34) shows that, for both males and females, the largest possible gain in life expectancy in the most deprived areas is from CHD, with a gain of around 1.3 years for males and 0.7 years for females if they had the same mortality rate as those in the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

Figure 33: Breakdown of life expectancy gap between the most deprived and least deprived quintile in Eastbourne by cause of death, 2001–2005



Source: London Health Observatory

Figure 34: Possible gain in life expectancy in Eastbourne, 2001–2005



Source: London Health Observatory

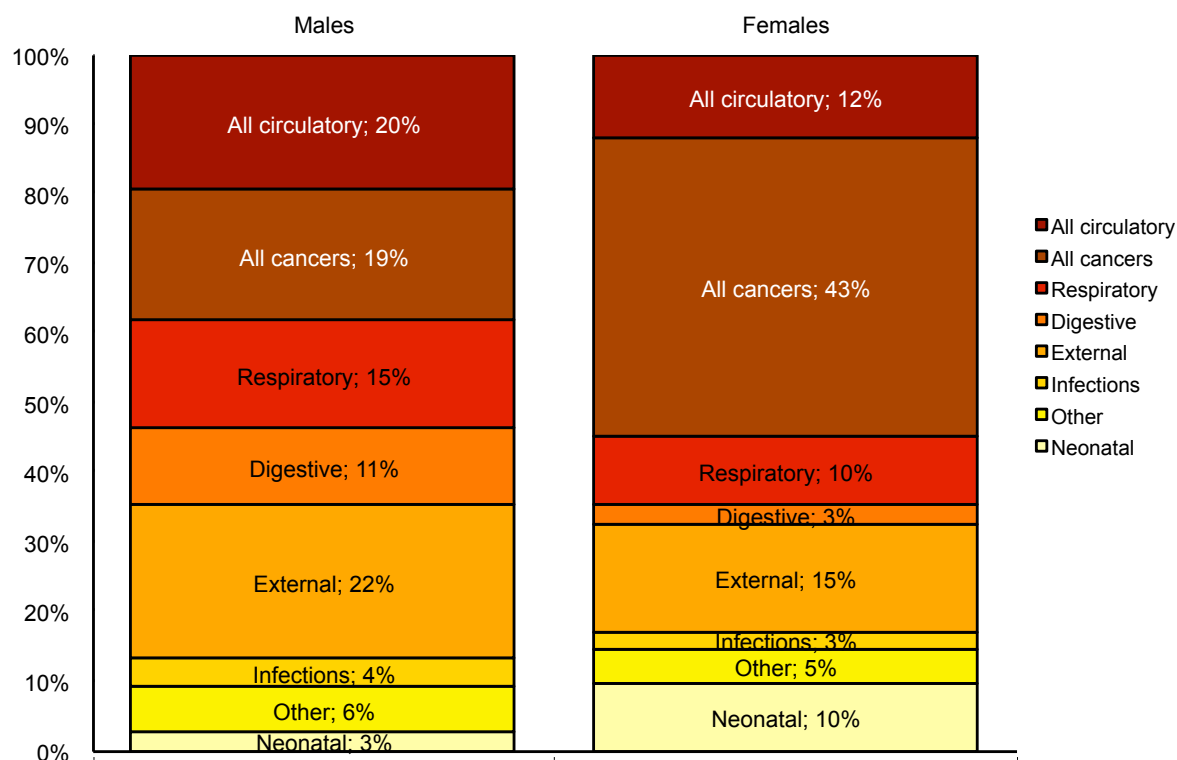
Table 8 shows the age groups in which there are significant differences in mortality rates for circulatory, cancer and respiratory conditions between the most and least deprived areas of Eastbourne.

Mortality from circulatory diseases is higher in the most deprived quintile in Eastbourne compared to the least deprived across all ages for 2004–2008, except people aged 85 years or over. Mortality from circulatory diseases is significantly higher in those aged 65–69 years in the most deprived quintile, and this can also be seen in mortality from CHD. Over a five year period, there were 24 deaths from CHD in the most deprived quintile in people aged 65–69 years compared to six in the least deprived quintile.

In 2001–2005, the gap in life expectancy was 5.5 years in males and 2.3 years in females 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%), see Figure 35.

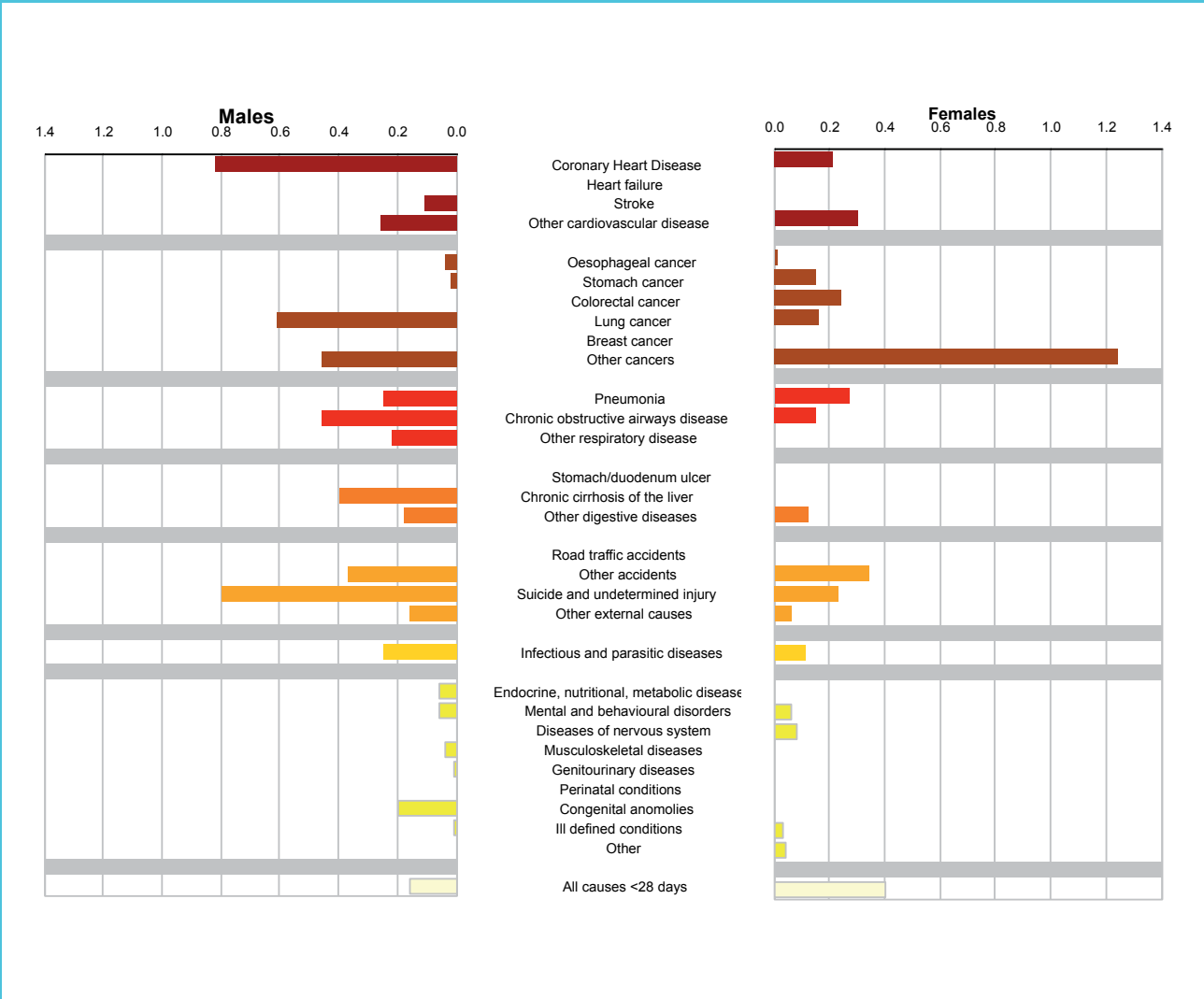
Breaking down the life expectancy gap further shows that the years of life that could be gained for males in the most deprived areas of Hastings are largest for CHD (0.82 years), suicide (0.8 years) and lung cancer (0.61 years) (Figure 36). In females, the largest gain would be from ‘other cancers’ (excludes 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 35: Breakdown of life expectancy gap between the most deprived and least deprived quintile in Hastings by cause of death, 2001–2005



Source: London Health Observatory

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



Source: London Health Observatory

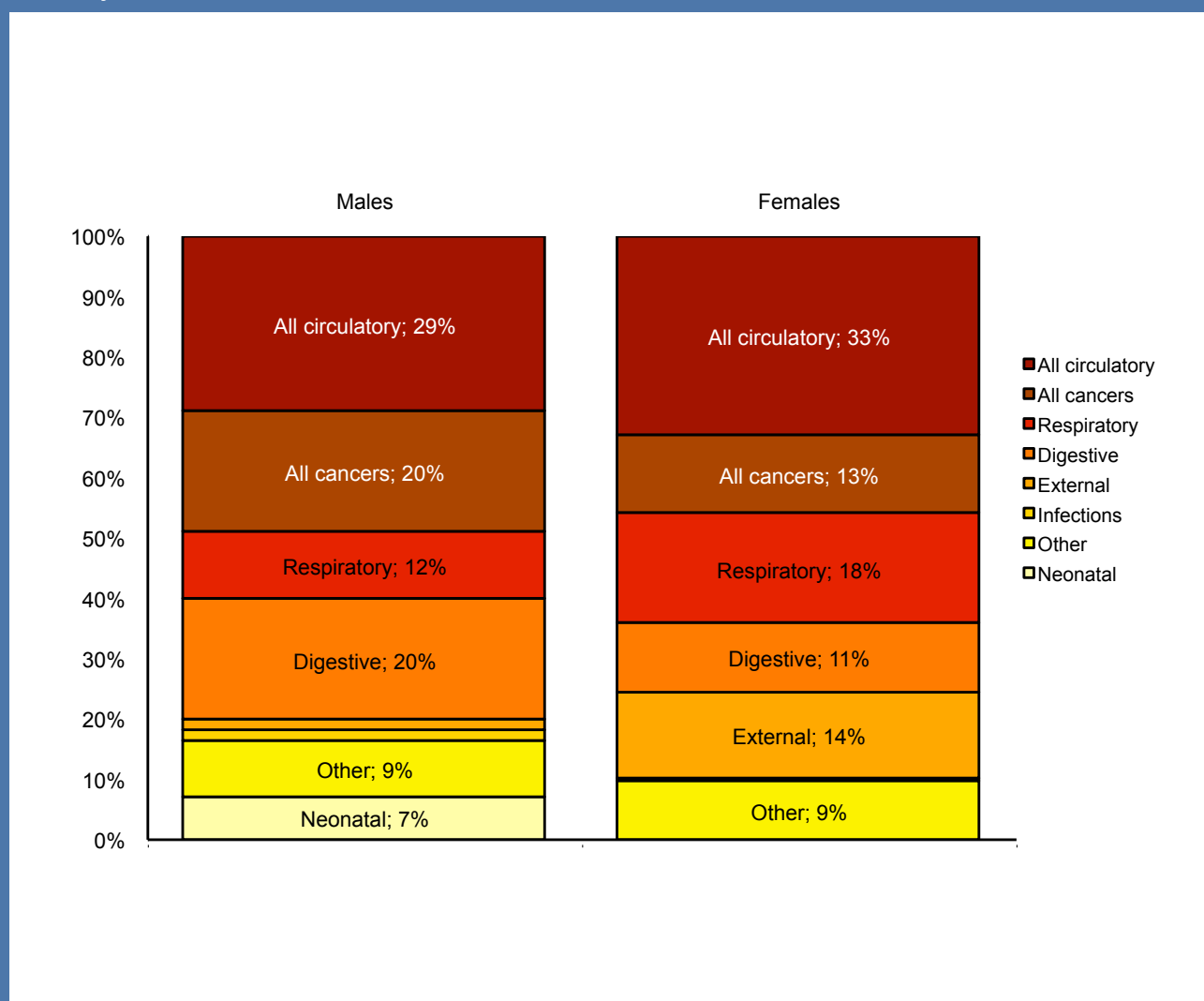
Table 9 shows the age groups in which there are significant differences in mortality rates for circulatory, cancer and respiratory conditions between the most and least deprived areas of Hastings.

Across most ages, mortality from circulatory diseases is higher in the most deprived areas of Hastings, with rates being significantly higher for those aged 60–64 years (in 2004–2008 there were 19 deaths from respiratory diseases in those aged 60–64 years in the most deprived areas of Hastings compared to less than five in the least deprived areas).

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%), see Figure 37.

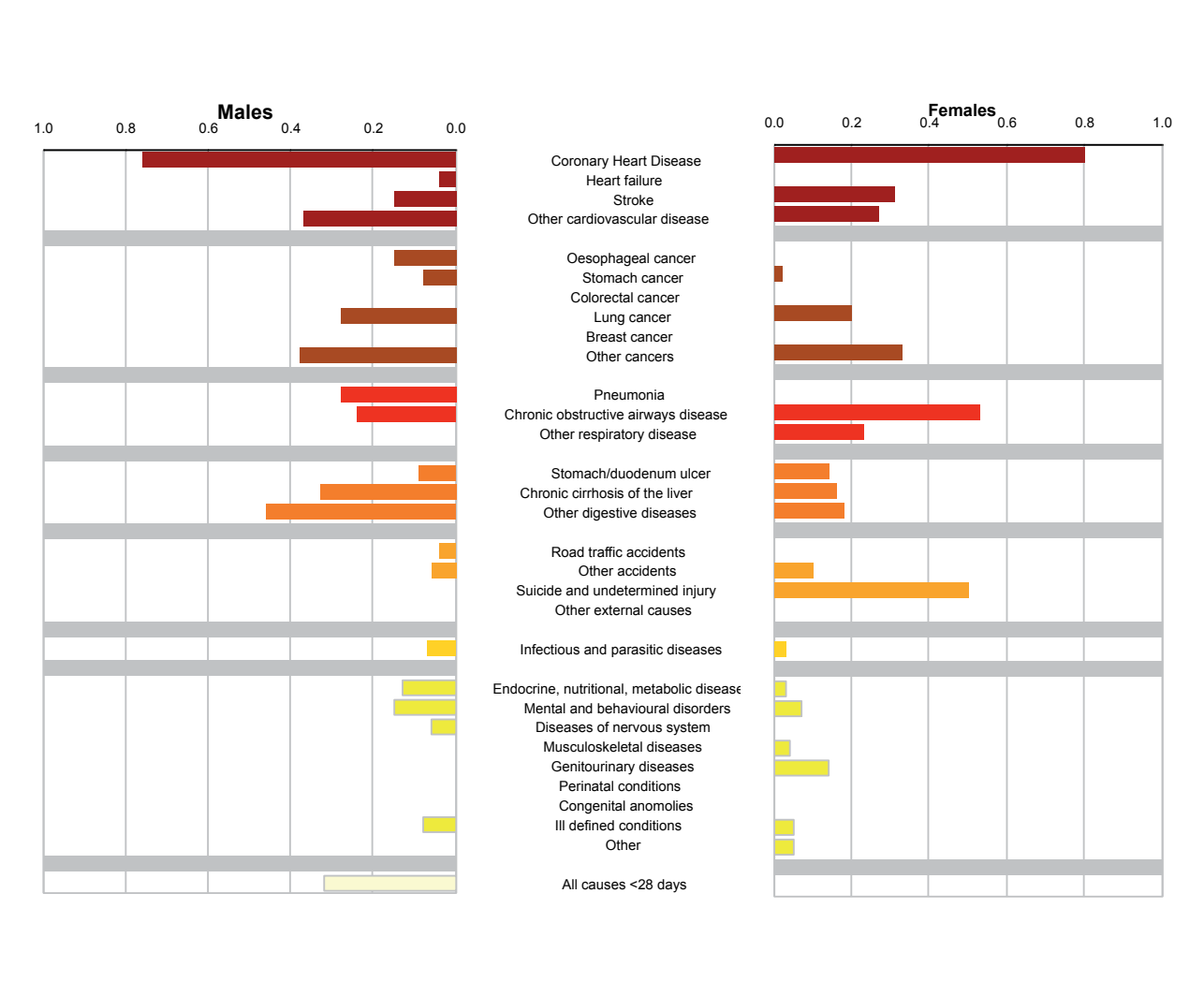
Further analysis of the gap in life expectancy during 2001–2005 shows that, in both males and females, the largest years of life that could be gained if those in the most deprived areas experienced the same mortality as those in the least, is in mortality from CHD (0.76 and 0.80 years, respectively).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

Figure 37: Breakdown of life expectancy gap between the most deprived and least deprived quintile in Lewes by cause of death, 2001–2005



Source: London Health Observatory

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



Source: London Health Observatory

Table 10 shows the age groups in which there are significant differences in mortality rates for circulatory, cancer and respiratory conditions between the most and least deprived areas of Lewes.

Across the majority of ages, mortality from circulatory conditions is higher in the most deprived areas of Lewes. There are significant differences in those aged 65–69 years with 24 deaths during 2004–2008 in the most deprived areas compared to nine in the least deprived.

Table 10: *Significant differences in mortality rates in Lewes*

	Circulatory			Cancer			Respiratory		
	All circulatory	CHD	Stroke	All cancer	Lung	Breast	All respiratory	Pneumonia	Bronchitis, emphysema & COPD
Lewes	65–69			65–69	65–69, 75–79				

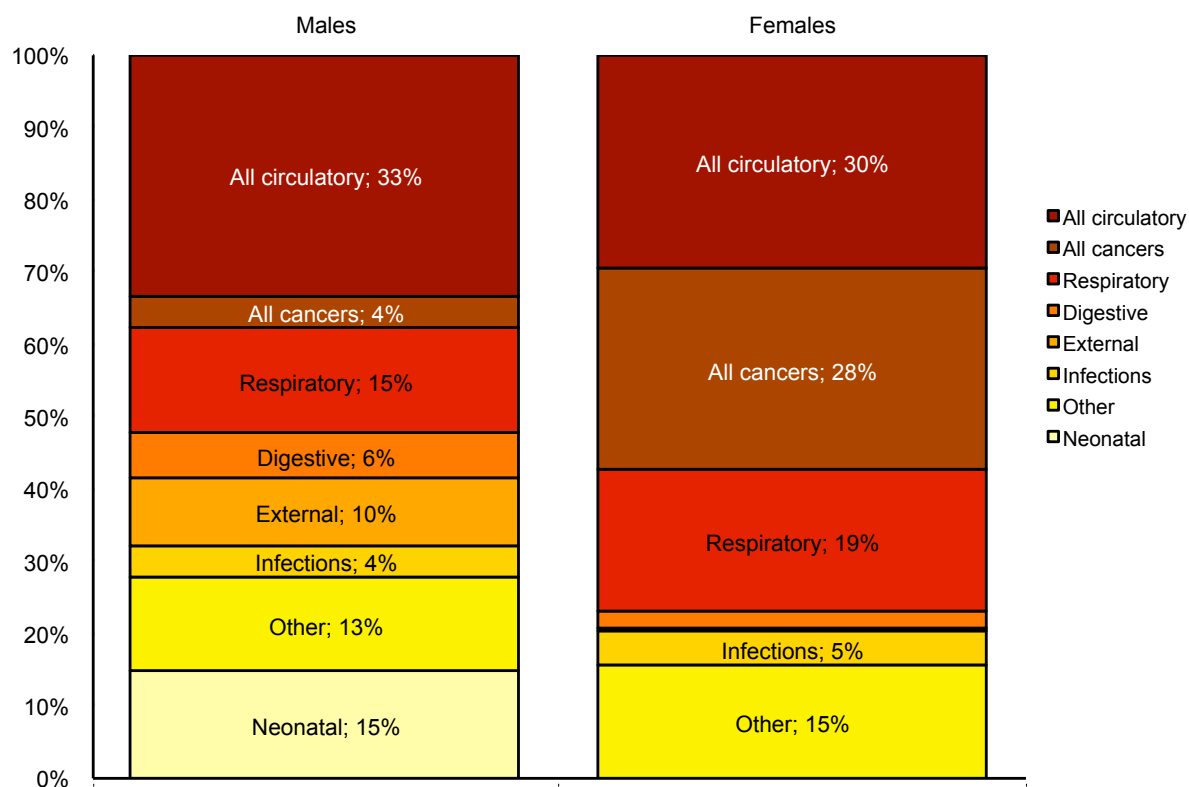
There are significant differences in mortality from cancer between the most and least deprived areas of Lewes in people aged 65–69 years (38 deaths in the most deprived compared to 19 in the least over five years). Significant differences can also be seen in mortality from lung cancer in those aged 65–69 years, as well as 75–79 years. In 65–69 year-olds over a five year period, there were 11 deaths within the most deprived areas compared to less than five in the least; in 75–79 year-olds, there were 24 deaths in most deprived areas compared to six in the least.

Mortality rates from all respiratory conditions, as well as specifically from bronchitis, emphysema and COPD, are higher across all ages in the least deprived areas.

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 4% of the gap in males but 28% of the gap in females (Figure 39).

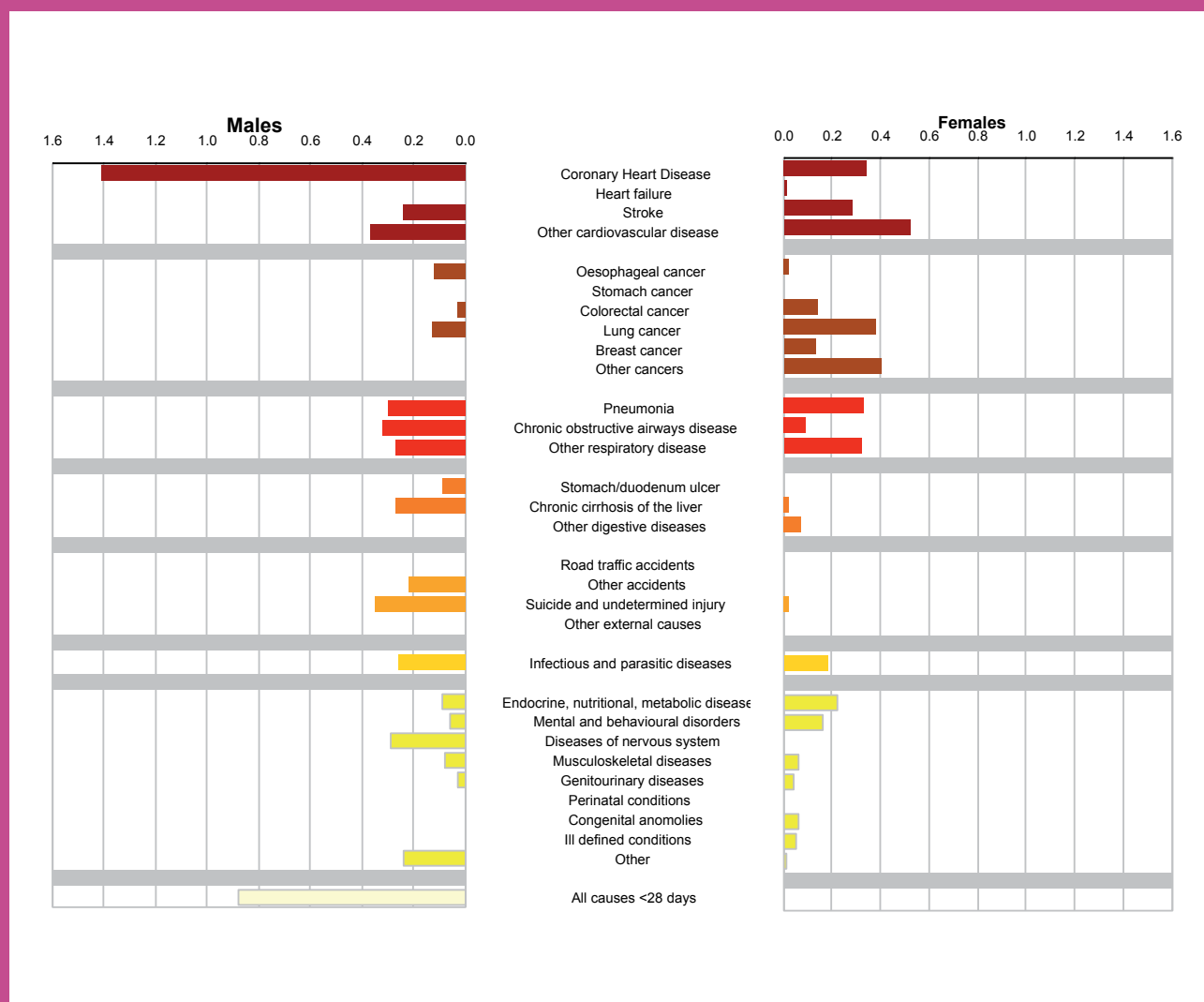
Breaking down the gap in life expectancy further shows that, if males from the most deprived areas in Rother experienced the same mortality rates for CHD and deaths within 28 days of birth as those in the least deprived, there could be a gain in life expectancy of 1.41 and 0.88 years, respectively (note 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), with a potential gain of 0.52 years, see Figure 40.

Figure 39: Breakdown of life expectancy gap between the most deprived and least deprived quintile in Rother by cause of death, 2001–2005



Source: London Health Observatory

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



Source: London Health Observatory

Table 11 shows the age groups in which there are significant differences in mortality rates for circulatory, cancer and respiratory conditions between the most and least deprived areas of Rother.

Mortality from circulatory diseases is higher across all ages in the most deprived areas of Rother compared to the least deprived, with significant differences in those aged 65–74 years. Significant differences can be seen in mortality rates from CHD in those aged 65–69 years, at 14 deaths in the most deprived areas compared to less than five in the least deprived areas during 2004–2008.

Table 11: Significant differences in mortality rates in Rother

	Circulatory			Cancer			Respiratory		
	All circulatory	CHD	Stroke	All cancer	Lung	Breast	All respiratory	Pneumonia	Bronchitis, emphysema & COPD
Rother	65–74	65–69		60–64					

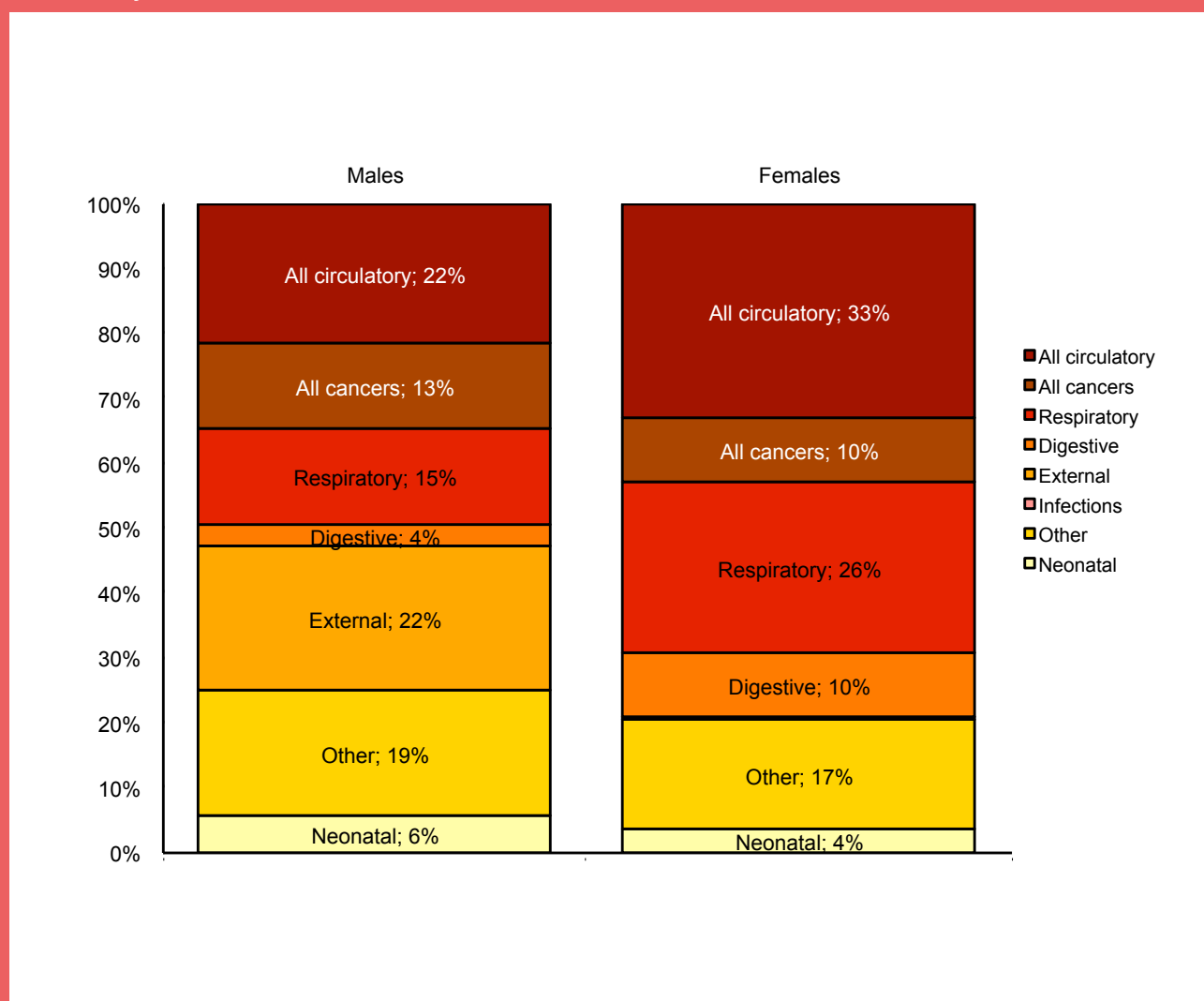
Those aged 60–64 years in the most deprived areas of Rother have a significantly higher rate of mortality from all cancers compared to those from the least deprived areas (over a five year period, there were 31 deaths in the most deprived areas compared to 15 in the least). Mortality rates from lung cancer are higher across all ages in the most deprived areas, but not significantly.

Across all ages, there are higher mortality rates in the most deprived areas from all respiratory conditions, as well as specifically from bronchitis, emphysema and COPD, but not significantly.

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 (33%) and respiratory diseases (26%), see Figure 41.

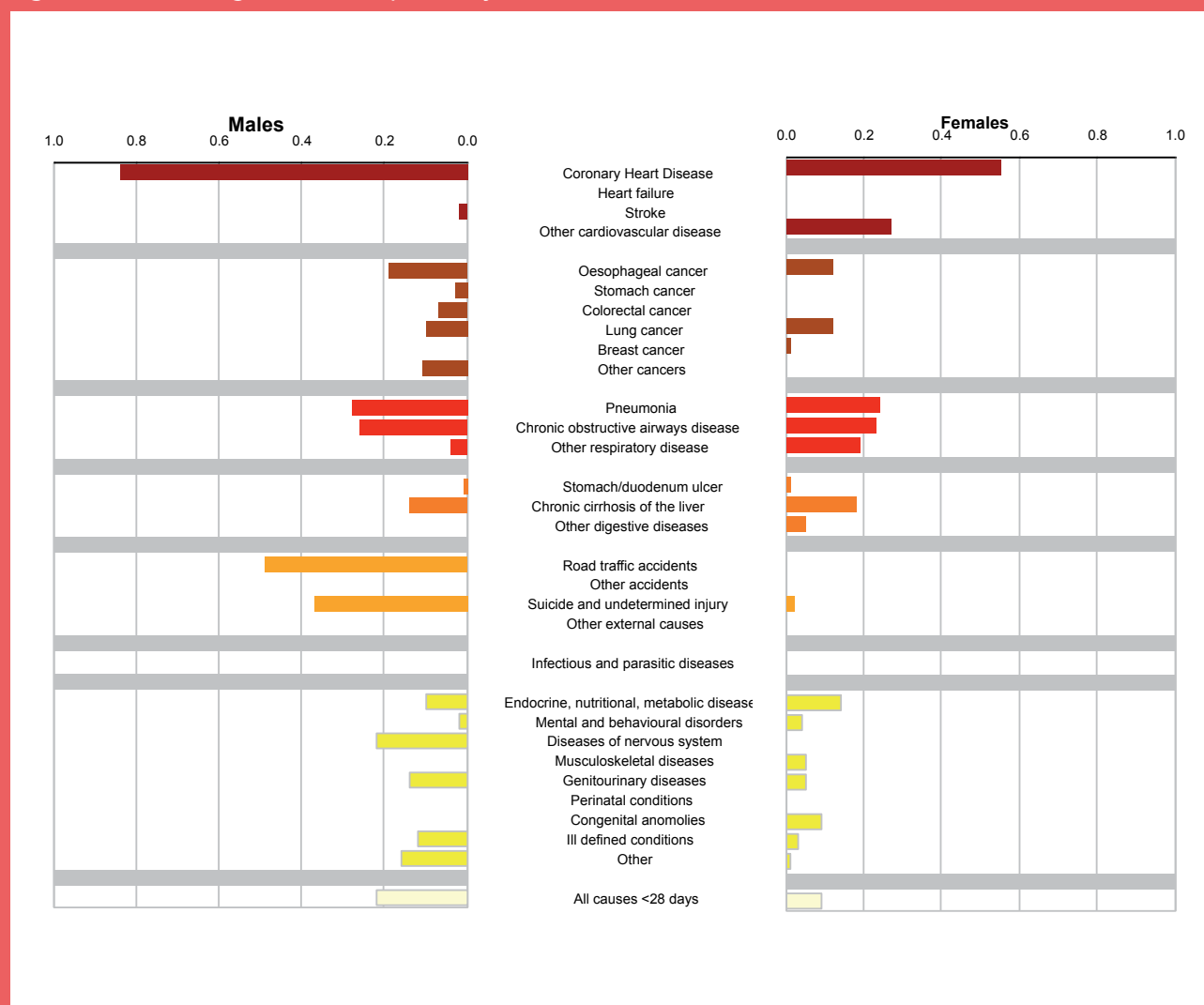
Further analysis of the breakdown of the gap in life expectancy shows that, in males from the most deprived areas, the largest potential gains in life expectancy are from CHD (0.84 years) and road traffic accidents (0.49 years) (Figure 42). In females, if those experienced the same mortality from CHD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

Figure 41: Breakdown of life expectancy gap between the most deprived and least deprived quintile in Wealden by cause of death, 2001–2005



Source: London Health Observatory

Figure 42: Possible gain in life expectancy in Wealden 2001–2005



Source: London Health Observatory

Table 12 shows the age groups in which there are significant differences in mortality rates for circulatory, cancer and respiratory conditions between the most and least deprived areas of Wealden.

Significant differences in mortality from circulatory diseases can be seen between the most and least deprived in Wealden in people aged 70–79 years. Mortality rates from CHD are significantly different in those aged 55–59 years: there were 11 deaths in the most deprived areas compared to none in the least during 2004–2008.

Joint Strategic Needs Assessment Programme

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; and focused work on increasing life expectancy.

1. JSNA Indicator Scorecards

During August and early September 2007, local indicator scorecards were developed that 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 and Wellbeing, March 2007. As part of this work, the Doncaster Model (a QOF benchmarking tool developed by Doncaster PCT) was used to investigate the 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, 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 by focusing on the very limited consideration given to children. As a result of this new guidance, additional scorecard work was undertaken to produce a Children's Supplement that 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

JSNA scorecard profiles

Based on the 2009 JSNA scorecards, district/borough local authority profiles have been produced and are reproduced here.

Demography

- East Sussex has an estimated population of 514,767 people. Wealden has the largest population, with 145,882 people, which is 49% larger than the next largest district Eastbourne, with 97,691 people. Hastings has the smallest estimated population, with 87,188 people.
- Hastings has the highest fertility rate, at 68 per 1000 population compared to the lowest of 55 per 1000 population in both Lewes and Wealden.
- Hastings has the highest proportion of children aged 0–4 years as a percentage of the total population, at 5.9%. The proportion is extremely high at Tressell (8.9%) and Hollington (8.3%). This compares to the lowest with 4.3% in Rother. Particularly low is Bexhill Collington, at just 2%.
- In Hastings, there are 10,482 children aged 5–14 years, which represents 12.0% of the local population. This is the highest district proportion; Hollington has 17.9% (the highest proportion for wards in the county). In contrast, Eastbourne has the lowest proportion of 5–14-year-olds, at 10.5%; the proportions in Meads and Upperton wards are particularly low, at 4.8% and 6.2%, respectively. Eastbourne also has some wards with high proportions, in Hampden Park and especially Langney, at 17.6%.
- Hastings district has the highest proportion of 0–64 year-olds as a percentage of the total population, with 82.6%, whereas Rother has only 71.9%. The county average is 22.6% of the population aged 65 years and over. Rother has a much more elderly population, with 28.1% aged 65 years and over. It is especially high in Bexhill Sackville (44.8%), Bexhill Collington (43.6%) and Bexhill Kewhurst (38.1%).
- Eastbourne district has the largest projected percentage increase in population compared with the other districts, at a 3.7% increase by 2011 (2.1% East Sussex average) and 6.2% by 2013 (3.5% East Sussex average), from the 2008 baseline. Eastbourne is projected to have an increase across all age ranges. The other districts are projected to have minimal change

for those aged 0–64 years (0.7 increase by 2013 for the county and a decrease of 0.4% for those aged 0–19 years). In contrast, the county is expected to have an increase of 13.1% of those aged over 65 years, with Wealden having the largest, at 15.6%. The over 85 years age group is expected to increase by 8.8% in East Sussex by 2013 and this is predicted to be higher for Lewes (10.8%) and for Wealden (10.2%).

- The county has less diversity in terms of ethnicity and religion. Only 2.3% of people in East Sussex are from a non-White ethnicity and 1.3% of the population belong to a main religion other than Christianity, compared to 5.5% and 8.7%, respectively, for England (Census 2001). Eastbourne is the most diverse district, with 3.4% of people from a non-White ethnicity and 1.9% of the population belonging to a main religion other than Christianity. Wealden is the least diverse, with 1.7% from a non-White ethnicity and only 0.9% belonging to a main religion other than Christianity.

Social/environmental context

- Hastings is the most deprived district, with a score of 32.21, almost twice the county average of 18.78. Eight Hastings wards are in the 90th percentile or above, with Central St Leonards being the most deprived ward in the county, with a score of 55.18. Eastbourne is the second most deprived district, which is significantly less deprived than Hastings, at a score of 23.36. Wealden is the least deprived district (over three times less deprived than Hastings), with a score of 10.86.
- It should be noted that the Index of Multiple Deprivation is calculated nationally at the LSOA level, which represents a smaller area than wards. Hastings has 14 LSOAs in the top 10% ranked nationally and 29 LSOAs in the top 30% most deprived nationally out of its 53 LSOAs. Eastbourne has only one LSOAs in the top 10% nationally and 20 LSOAs in the top 30% most deprived nationally out of Eastbourne's 53 LSOAs.

- 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 a low income in Hastings, which is defined as less than 60% of the national median income. This reduces to one in four for Eastbourne and Rother (26% and 25.8%). For Lewes and Wealden, it is one in five (21.7% and 19.5%).
- In East Sussex, 63% of persons aged 18–64 years with learning disabilities are in settled accommodation. This is much lower than in Rother, which has only 50%.
- One in eight (12.6%) claim out-of-work benefits in East Sussex. This is much higher in Hastings, where it is just over one in five (20.4%).
- In Hastings, 6.3% of people aged 16–59 years claim disability living allowance, compared to 4.4% for East Sussex. Several wards in Hastings have rates approaching ten percent. For example, Wishing Tree (9.8%), Baird (9.2%) and Gensing (8.8%).
- The 2001 Census showed that 38% of households are owned outright and 36% have a mortgage or loan. 5.4% of East Sussex households are rented from council/local authority, at 9.6% in Eastbourne (particularly high in Hampden Park and Langney) and 8% in Lewes. Furthermore, 6.4% of households are rented from a housing association/registered social landlord. That is over twice the figure for Hastings, at 13.7% (very high in Hollington, Wishing Tree and Baird wards) and 8.7% in Rother with 24.7% in Sidley ward.
- In Hastings 17.8% of households are rented from a private landlord compared with 9.9% for East Sussex.
- In East Sussex, 5.6% of people live in overcrowded households. This rises in Eastbourne to 8.6% and in Hastings to 7.3%. In the most deprived wards, the numbers are significantly higher; so, for example, St Leonards ward had 14.4%. When looking at those aged under 18 years living in overcrowded households, there are higher percentages.

East Sussex has 9% of people in that age group living in overcrowded housing, compared to 11% in Hastings and 10% in Eastbourne. (Census 2001).

- One in three households in Hastings (33.8%) and 31.7% in Eastbourne have no access to a car or van, which is noticeably higher than the county average of 23.4%. (Census 2001).
- Just over one in three (34%) older people aged 65 years and over live alone. (Census 2001).
- Forty five per cent of primary school children travel to school by car/van or taxi in East Sussex. This rises in the more rural districts to 51% in Rother and 50% in Wealden. For secondary school pupils, the county average is one in five (19%), with the highest percentages in Eastbourne and Hastings, at 25% and 24%, respectively.

Lifestyle and risk factors

- 78% of mothers start breastfeeding in East Sussex, but this falls to 52% at six to eight weeks of age. In Wealden and Lewes, 59% are breastfeeding fully or partially at six to eight weeks but this falls to 44% in Hastings.
- One in five (20%) of East Sussex's 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%, and one in three (33%) of Year 6 pupils in Rother. For adults, only one in five (20%) 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 smoke at the time of delivery. This rises significantly to 27% for Hastings.
- The teenage pregnancy rate for the county is 37 per 1000 population 15–17-year-olds. The rate is much higher in Hastings, at 59 per 1000 population.
- The estimated prevalence of binge drinking for adults is 14%. In all, 1,454 per 100,000 population in East Sussex were admitted to hospital due to an alcohol harm-related episode. Eastbourne has the highest rate, at 1,874 per 100,000 population with Hastings slightly less with 1,729 per 100,000 population. In East Sussex, there were 81 per 100,000 hospital admissions due to alcohol-specific

conditions in persons aged under 18 years. Hastings had double this rate with 166 per 100,000 population.

Burden of ill-health

- In East Sussex, 77% of people surveyed rated their health as either very good or good.
- The county has a Mental Illness Needs Index 2000 of 0.91, which suggests 9% less illness in the area compared to the country as a whole. In comparison, Hastings has an index of 1.47, or 47% more illness severe enough to need hospital treatment from time to time.
- The Index of Common Mental Illness shows that 12.8% of the county aged 16–64 years suffer from neurotic symptoms and 7.2% from depression.

Burden of ill-health – mortality

- Life expectancy at birth in East Sussex is 81 years, with the highest in Wealden, at 83 years versus 79 years for Hastings. In East Sussex, life expectancy is 20 years at aged 65.
- All age, all cause, age-standardised mortality reveals that Hastings has 24% more deaths than expected, whereas Lewes has 10% less.
- In under-75s, age-standardised deaths from circulatory diseases are 21% higher in Hastings than expected, while in Lewes deaths are 12% lower than expected.
- Age-standardised stroke mortality for all persons is 15% less in Eastbourne than expected but 27% more in Hastings.
- Age-standardised cancer mortality in under-75s is 13% above the East Sussex average, but 11% less in Wealden.
- COPD mortality is 66% more than expected in Hastings, whereas it is 21% less than expected in Rother.
- Mortality from causes considered amenable to healthcare is 22% higher than the county average for Hastings, while Wealden and Lewes have 10% and 13% less mortality than expected.
- Mortality from suicide in Eastbourne and Hastings is 22% and 17% higher, respectively, than expected.

Burden of ill-health – primary care

- East Sussex has a GP-reported prevalence for cancer that is 51% greater than expected, with an even higher figure for Rother and Wealden, at 65% and 59%, respectively, more than expected.
- The GP-reported COPD prevalence is 6% greater than expected. This compares with 8% less than expected in Rother and 19% more than expected in Wealden.
- East Sussex has a GP-reported prevalence for CHD that is 19% less than expected. Hastings is 26% less than expected.
- Hastings has a 4% greater than expected GP-reported prevalence for epilepsy, whereas East Sussex has a prevalence 14% less than expected.
- East Sussex has a GP-reported prevalence for heart failure that is 59% less than expected, with a reported figure of 77% less than expected in Eastbourne.
- Wealden has a reported prevalence for hypothyroidism that is 74% higher than expected. This compares with East Sussex, which has a prevalence 58% more than expected and Hastings, which has the lowest, at 41% more than expected.
- Diabetes mellitus is reported at only 76% of the expected level.
- Reporting of dementia is only 31% of predicted level.
- Mental illness is reported at over two times (102%) the predicted level for East Sussex and reported at over one and a half times the predicted level (156%) in Hastings.
- East Sussex has a GP-reported prevalence for stroke or TIA which is 12% less than expected.

Burden of ill-health – hospital care

- A&E attendances in under-fours are 153 per 1000 population in East Sussex. Hastings has an attendance rate of 225 per 1000 population and Eastbourne a rate of 181 per 1000 population. Above-the-county-average A&E attendances persist for Hastings and Eastbourne through childhood 5–9, 10–19 and for all age ranges.
- Emergency hospital admissions for persons aged 1–4 years are 169 per 1000 population for the county. Hastings has nearly 50% more, with 244 per 1000 population. Well-above-average emergency hospital admissions persist in Hastings for children aged 5–9 years and 10–19 years.
- Emergency hospital admissions due to infections for persons aged 0–4 years in Hastings was one and a half times (47 per 1000 population) that of East Sussex (19 per 1000 population) and two thirds higher in Rother (32 per 1000 population).
- Emergency hospital admissions due to symptoms and signs without definitive diagnosis for persons aged 0–4 years is very high for Eastbourne, at 56 per 1000 population, which is in highest amongst the districts with the county average 39 per 1000 population.
- Emergency hospital admissions caused by unintentional and deliberate injuries for those aged under 18 was 166 per 1000 population. Lewes was substantially lower, at just 108 per 1000 population, while Hastings was nearly 50% higher at 248 per 1000 population.
- All emergency hospital admissions (age-standardised ratio) shows Hastings with 32% more admissions than expected compared to Lewes and Wealden, which were 18% and 12%, respectively, lower than expected.
- Hastings and Rother have emergency admissions (age-standardised) due to circulatory diseases that are 30% and 15% above the level in East Sussex as a whole.
- Emergency (age-standardised) admissions for CHD are 20% and 15% above that expected for Hastings and Rother.
- Total hospital admissions due to cancer were higher for Rother, Eastbourne and Hastings, with 20%, 18% and 18%. Whereas in Lewes and Wealden, it was much lower, at

33% and 12%, respectively, below the expected level. A similar pattern appears for both elective and emergency hospital admissions for cancer.

- Emergency hospital admissions due to stroke (age-standardised) shows Hastings and Rother 36% and 11%, respectively, above the expected number.
- Emergency admissions (age-standardised) due to respiratory diseases for Eastbourne and Hastings are 11% and 31%, respectively, above the level in East Sussex as a whole.
- Emergency hospital admissions due to COPD was significantly higher for Hastings, at 66% above that expected. This was also very high for mental and behavioural disorders and diabetes, which was 54% and 39%, respectively, higher than expected.

Services – social care

- Referrals to adult social care is 37 per 1000 population in East Sussex. In Wealden, 31 per 1000 population are referrals, rising 43 per 1000 population in Rother.
- 18 per 1000 persons aged 18–64 years are supported to live independently through social services. For Hastings, this is a third more, at 24 per 1000 population. For those aged over 65 years, the rate is 93 per 1000 population in East Sussex. Hastings has the highest rate, at 116 per 1000 population.
- 8 per 1000 persons aged 18–64 years with physical disability, frailty and sensory impairment are supported to live independently through social services in East Sussex. In Hastings, this rises to 10 per 1000 population. The rates for those aged 65 years and over are, as expected, much higher. In Hastings, it was 88 per 1000 population. In Eastbourne and Hastings the figure was higher, at 98 and 99 per 1000 population.

Services – health

- 83% of two-year-olds were immunised for Pneumococcal infection in East Sussex. This reduces to 76% in Lewes. Similarly, Lewes has a low uptake, with just 86% of two-year-olds immunised for Haemophilus influenzae, which compares to 90% for the county as a whole.
- 89% of two-year-olds and 86% of five-year-olds have received the MMR vaccine in East Sussex. Rother has only a 75% uptake for five-year-olds.
- 27 per 10,000 population of young people aged 0–18 years are in drug or alcohol treatment. Both Hastings and Rother have higher rates (42 and 40 per 10,000 population). The rate for East Sussex for adult clients aged 19 years and over in drug treatment was 20 per 10,000 population. Hastings continues to have a higher rate than the county average along with Eastbourne 42 per 10,000 population and 27 per 10,000 population.
- Lewes has an uptake of Chlamydia screening of just 1% compared with 5% for East Sussex.
- Eastbourne has the lowest cervical screening uptake, at 77% of eligible women. All wards are below the county average of 80%.
- The uptake of breast screening for eligible women in Eastbourne is the lowest in the county, at just 50% compared to the 70% for East Sussex. All wards are low, but particularly Old Town, at just 32% the lowest in the county.
- Eastbourne and Wealden had a 67% and 68% uptake of pneumococcal vaccine, respectively, for persons aged 65 years and over, compared to the county average of coverage of 70%.

Services – children's services

- In East Sussex, 11.3% of pupils receive free school meals. This figure is much higher in Hastings and Eastbourne, at 18.2% and 14%.
- Eastbourne has the highest rate (79.3 per 1000 population) of pupils with English as an additional language, compared to the county average of just 35.8 per 1000 population.
- The highest rate of children with an allocated social worker is 70 per 1000 population in Hastings, which is significantly higher than the county average of 38 per 1000 population.

User perspectives on services

- 94% of respondents in East Sussex said they were satisfied with care received at their GP surgery.
- In Lewes, 69% of people said they were able to book to see a doctor fairly quickly in the last six months, compared to 73% for East Sussex as a whole. In Rother, this was noticeably higher, at 83%.
- 84% of people in East Sussex said they were able to see their preferred doctor always, almost always or a lot of the time; in Lewes, it was just 80%.
- 32% of older people said they received the support they need to live independently at home in East Sussex. This is lower in Hastings, at just 29%, but slightly better in Lewes, with 35%.

Demography

- Eastbourne is the second most populated district, with an estimated 97,691 people.
- The highest fertility rate in Eastbourne is found in Devonshire, at 86 per 1000 population), Meads has the lowest, at 34 per 1000 population.
- Langney and Hampden Park have the highest percentage of 5–14 year-olds of the total Eastbourne population, at 17.6% and 14.2%, respectively, both of which are in the top decile for the county. This contrasts with Meads and Upperton, which are in the bottom decile in the county, with only 4.8% and 6.2%.
- The largest percentage of total population aged 85 years and over in Eastbourne is in Meads (8.6%) and Upperton (8%), both in the top decile for the county. This compares with the East Sussex average of 3.8%.
- Eastbourne district has the largest projected percentage increase in population compared with the other districts, with a 3.7% increase by 2011 (versus 2.1% for the East Sussex average) and 6.2% by 2013 (versus 3.5%) from the 2008 baseline. Eastbourne is projected to have an increase across all age ranges, whereas there are minimal changes across the rest of the county (in fact, a slight reduction for all the other districts) among those aged 0–64 years. For Eastbourne, the proportion of people aged 65 years and over is projected to increase more (11.2% by 2013) than that for those aged 0–64 years (4.7% by 2013), although this increase is lower than the increase for those aged 65 years and over for the rest of the county (13.1% by 2013). The increase for those aged over 65 years is particularly high for males (16.4% by 2013). However, it should be noted that males aged 65 years and over start from a much lower baseline than females.
- The county has less diversity in terms of ethnicity and religion compared to England's average. Only 2.3% are from a non-White ethnicity, and 1.3% of the population belong to a main religions other than Christianity, compared to 5.5% and 8.7%, respectively, for England (Census 2001). Eastbourne is the most diverse district, with 3.4% from a non-White ethnicity and 1.9% belonging to a main religions other than Christianity.

Social/environmental context

- After Hastings, Eastbourne is the most deprived district in East Sussex. The most deprived ward is Devonshire, which is in the top decile in East Sussex, with a score of 34.27 compared to the county average of 18.78. Hampden Park, Langney and Upperton wards are all in the top quartile (most deprived 75–100%) for the county. It should be noted that the Index of Multiple Deprivation is calculated nationally for LSOAs, which are smaller areas than wards. Thus, Devonshire ward has five LSOAs in the top 30% ranked nationally. It has one LSOA in the top 10% and two in both the top 20% and 30% most deprived nationally. Hampden Park has three LSOAs in the top 20% and one in the top 30%. Langney has two LSOAs in the top 20% and one in the top 30%. It is important to be aware that there are pockets of deprivation within wards. In Eastbourne, Old Town and St Andrews are relatively less deprived wards, but they do contain LSOAs that are ranked in the 30% most deprived LSOAs in the country.
- One in four (26.0%) households are on low income, which is defined as less than 60% of national median income. Devonshire and Hampden Park, at 31.8% and 31.7%, respectively, are both in the top decile for the county.
- Three wards (Upperton, Langney and Meads) have a low percentage of persons aged 18–64 years with learning disabilities in settled accommodation.
- Almost one in six (14.9%) claim out-of-work benefits. Devonshire, Hampden Park, Langney and Upperton have a much higher percentage of claimants and are in the top quartile in the county.
- In Eastbourne, 5% of people aged 16–59 years claim disability living allowance compared with 4.4% for East Sussex. The percentage is particularly high in Langney (7.3%), Hampden Park (6.9%) and Devonshire (5.9%).

- The 2001 Census showed that, in Meads, 53% of households owned their house outright and, in Ratton, the proportion was 49%. In Hampden Park, 21.4% of households and 23.2% of those in Langney were rented from the council/local authority. Old Town and St Anthony's both also have a high proportion (10.6% and 11%) of households rented from council/local authority. In Hampden Park, 14.8% of households are rented from housing association/registered social landlord. Devonshire, Upperton and Meads were all in the top decile for the county, with 26.3%, 21.7% and 19.6% of households rented from a private landlord.
- In Eastbourne, 8.6% lived in overcrowded households (the highest rate in East Sussex), with one in 10 under-18s in overcrowded homes. (Census 2001)
- One in three households (31.7%) have no access to a car or van, rising to 43.8% in Devonshire, 41.7% in Upperton and 38.2% in Meads. (Census 2001)
- Nearly two in five (37%) older people aged 65 years and over live alone. In Devonshire, this rises to 48% and in Upperton 43%. (Census 2001)
- Three in five children travel to primary school by car/van or taxi in Old Town and Upperton ward, compared to two in five children in Eastbourne. For secondary school pupils, the highest percentage of those travelling to secondary school by car/van or taxi is Meads (46%), St Anthony's (37%) and Sovereign ward (35%), compared to 25% for Eastbourne.
- 23% of Eastbourne Reception Year children are overweight or obese. This compares to 20% for East Sussex. Sovereign ward has the highest figure in East Sussex, at 39%. The figure for Year 6 pupils for Eastbourne is 27%, which is slightly less than the county average of 28%. Sovereign is the highest in Eastbourne, at 34%. For adults, less than one in five (19%) participate in sport and active recreation. The estimated adult level of obesity is 22%.
- One in five mothers are known to smoke at the time of delivery. This rises to 30% for Langney and 27% for Hampden Park.
- Teenage pregnancies (46 per 1000 population in 15–17-year-olds) are much higher than the county average (37 per 1000 population). In Ratton, the rate is only 12 per 1000 population.
- 25% of adults smoke.
- 78% of people report their health as either good or very good. However, for Langney, this figure is only 66%.

Burden of ill-health

- Eastbourne has a Mental Illness Needs Index 2000 of 1.03, which suggests 3% more illness in the area than the country as a whole. Devonshire has an index of 1.32, or 32% more illness severe enough to need hospital treatment from time to time.
- The Index of Common Mental Illness shows that, in the most deprived wards in Eastbourne, all are in the top quartile for the county for incidence of both neurotic symptoms and depression.

Burden of ill-health – mortality

- 75% of mothers start breastfeeding, but this falls to 48% at six-to-eight weeks of age. In Hampden Park, only 62% of mothers start breastfeeding and this reduces to 40% at six to eight weeks. Similar results are found in St Anthony's and Sovereign wards. In Langney, 71% start breastfeeding but only 35% are still breastfeeding at six-to-eight weeks.
- Life expectancy at birth in Eastbourne, at 81, matches the East Sussex average. This is substantially lower for Devonshire and Hampden Park, at 77.
- All age, all cause, age-standardised mortality is 3% above the East Sussex average. It is significantly higher in Hampden Park (33%), St Anthony's (30%) and Upperton (22%).
- The under-75s (age-standardised) deaths from circulatory diseases are 8% higher than in the county as a whole. Rates are 80% in Hampden Park and 68% higher in Devonshire.

- Age-standardised cancer mortality in the under-75s is 9% above the East Sussex average, it is 33% higher in Devonshire and 30% higher in Hampden Park.
- COPD mortality is only 6% above the East Sussex average. Again, there are large disparities with Devonshire, Hampden Park and St Anthony's more than 50% above this level.
- Mortality from causes considered amenable to healthcare is 72% higher than the county average in Hampden Park and 59% in Devonshire.
- Mortality from suicide in Devonshire is over double the county average.

Burden of ill-health – primary care

- GP-reported cancer prevalence is lower than the county average in all areas except Langney. For Eastbourne, the prevalence is 48% greater than expected.
- GP-recorded CHD is lower than the county average but 22% lower than the expected prevalence. Heart failure is reported at 33% of the expected level and hypertension at 52% of the expected level.
- Diabetes mellitus is reported at only 72% of the expected level.
- Reporting of dementia is only 26% of expected level.
- Mental illness is reported at over two times the expected level.

Burden of ill-health – hospital care

- A&E attendances in under-fours are 181 per 1000 population. The East Sussex average is 153 per 1000 population. The rates in central Devonshire (243 per 1000 population), Upperton (237 per 1000 population) and Meads (225 per 1000 population) are well above average.
- Above average A&E attendances persist through childhood, at both 5–9 years and 10–19 years.
- The overall age-standardised A&E attendances for Eastbourne are 17% above the East Sussex average (range –5% in Meads to 42% in Hampden Park).

- Emergency hospital admissions for persons aged 1–4 years are 195 per 1000 population, compared to the county rate of 169 per 1000 population. The highest rates in Eastbourne are found in Devonshire (268 per 1000 population), Upperton (259 per 1000 population) and Langney (211 per 1000 population), all of which are in the upper quartile range).
- Well-above-average emergency hospital admissions persist for children aged 5–9 years and 10–19 years in the Devonshire ward.
- Emergency hospital admissions due to symptoms and signs without a definitive diagnosis for persons aged 0–4 years are very high for Eastbourne 56 per 1000 population, which is in the top decile for the county. All wards are high and Devonshire is particularly high, with the second highest rate for a ward in the county. The rate is still very high for Eastbourne for persons aged 5–19 years.
- All elective admissions (age-standardised) are 14% above East Sussex average levels.
- Emergency (age-standardised) admissions for CHD are 4% lower than expected, while elective admissions are 13% higher. However, emergency admissions from Hampden Park are 56% above the level expected.
- Total hospital admissions due to cancer are 18% more than expected for Eastbourne.
- Emergency admissions (age-standardised) due to respiratory diseases are 11% above the level for East Sussex as a whole, rising substantially in Hampden Park, Devonshire, Upperton, St Anthony's and Devonshire. COPD emergency admissions are 19% above the East Sussex average, rising to over double in Hampden Park.
- Emergency hospital admissions due to pneumonia are particularly high for Hampden Park, St Anthony's, Upperton and Langney – all are in the top quartile, ranging from 43–33% more admissions than expected.

Services – social care

- Referrals to adult social care are 40 per 1000 population in Eastbourne, rising to 61 per 1000 population in Upperton, 52 per 1000 population in Meads and 45 per 1000 population St Anthony's.
- 19 per 1000 persons aged 18–64 years are supported to live independently through social services and this is just above the county average of 18 per 1000 population. It is significantly higher for Langney, Hampden Park and Devonshire (range 28–25 per 1000 population). For those aged over 65 years, the rate is high in Upperton and Hampden Park, at 130 per 1000 population compared to 97 per 1000 population for Eastbourne and 93 per 1000 population for the county.
- There are high rates for persons aged 18–64 years with physical disability, frailty and sensory impairment supported to live independently through social services in Langney (16 per 1000 population), which is double the county average, 14 per 1000 population in Hampden Park and 10 per 1000 population in Devonshire. The rates are also very high for those aged 65 years and over for Upperton (143 per 1000 population, highest in the county) and in Hampden Park (124 per 1000 population), compared with the county average of 88 per 1000 population.

Services – health

- 92% of two-year-olds and 88% of five-year-olds have received the MMR vaccine.
- There are high rates for young people aged 0–18 years in drug or alcohol treatment for Devonshire and Hampden Park (62 per 10,000 population and 51 per 10,000 population). The rates remain high for adult clients aged 19 years and over in drug treatment for Devonshire, Hampden Park, Upperton and Langney, ranging from 48 per 10,000 population to 31 per 10,000 population versus the county average of 15 per 10,000 population.
- Eastbourne has the lowest cervical screening uptake of 77% of eligible women. All wards are below the county average.

- The breast screening uptake for eligible women in Eastbourne is the lowest in the county, with just 50% compared to the 70% for East Sussex. All wards are low but particularly Old Town, with just 32%.

Services – children's services

- Fourteen per cent of pupils receive free school meals in Eastbourne. The proportion is higher amongst the most deprived wards, at 20.9% for Langney, 20.2% in Hampden and 16% in Devonshire.
- Eastbourne has the highest rate (79.3 per 1000 population) of pupils with English as an additional language, compared to a county average of just 35.8 per 1000 population. It is particularly high in Devonshire, which has the highest rate in the county, at 220.7 per 1000 population (six times the county average). Other wards with very high rates are Meads (144.2 per 1000 population), Ratton (101.2 per 1000 population) and Upperton (96.7 per 1000 population).
- Eastbourne district had the lowest assessments for the Foundation Stage, especially Hampden Park, Langney, Devonshire and Ratton.
- The highest rate of children with an allocated social worker for Eastbourne were for Devonshire, Hampden Park and Langney wards.

User perspectives on services

- In Eastbourne, 70% of people said they were able to book to see a doctor fairly quickly in the last six months, compared to 73% for East Sussex. Responses from Sovereign and St Anthony's were particularly low (62% and 64%, respectively).
- 32% of older people said they received the support they need to live independently at home in Eastbourne (the same as East Sussex). However, this was only 22% for Sovereign and 26% for Ratton.

Demography

- Lewes is the third most populated district, at an estimated 95,193 people.
- The highest fertility rate in Lewes is found at Peacehaven West, at 98 per 1000 population, which is the second highest rate in the county. Newick and Plumpton, Streat et al have the lowest rate, with 30 per 1000 population, with Chailey & Wivelsfield close behind at 32 per 1000 population.
- Newhaven Valley and Peacehaven East are both in the top decile for the percentage of children aged 0–4 years of total population (7.2% and 7%). Seaford West is the lowest, at just 2.9%. Lewes has 11.2% of 5–14-year-olds as a percentage of the total population. There are only small variations amongst the wards.
- There are a number of wards in the top quartile for the percentage of all persons aged 65 years and over. Peacehaven East, Peacehaven West, Seaford Central, Seaford East, Seaford South, and Ditchling & Westmeston (all above 26%). Seaford West is in the top decile for the county, with 35.1% of its total population aged 65 and over.
- Seaford Central and Seaford South are both in the top quartile for the county, with 6.9% and 7%, respectively, of their population aged 85 years, compared to the district average of 3.7%.
- The Lewes district projected percentage increase in population from the 2008 baseline is just below the county average for both 2011 (2% compared with 2.1% for the county) and 2013 (2.8% compared with 3.5% for East Sussex). There are minimal increases for those aged 0–19 and 0–64 years by 2011 and a slight decrease for these age ranges by 2013. When looking at those aged 65 years and over, the picture is very different. There is a predicted 6.4% increase by 2011 and 12.7% by 2013. Lewes has the highest projected increase for those aged 85 years and over, at 16.7% by 2011 and a slightly lower, but still the highest, district increase of 10.8% by 2013. The increase is significantly higher for males, at a 25% projected for males aged 85 years, compared to 3.8% for females (although males are starting from a much smaller baseline.)

- The county has less diversity in terms of ethnicity and religion compared to England. In East Sussex, only 2.3% of people are from a non-White ethnicity, while 1.3% belong to a main religion other than Christianity. This compares to 5.5% and 8.7%, respectively, for England as a whole. Lewes follows the county pattern, at 2.1% and 1.2%, respectively.

Social/environmental context

- After Wealden, Lewes is the least deprived district in East Sussex. It has a score of 14.79, compared to 18.78 for East Sussex. Newhaven Valley, Newhaven Denton and Meeching and Peacehaven East all suffer from deprivation greater than the county average.
- It should be noted that the Index of Multiple Deprivation is calculated nationally at the LSOA level, which is smaller areas than wards. Consequently, there are pockets of deprivation within wards. For example, there is one LSOA in the top 30% ranked nationally in each of the following wards: Lewes Castle; Seaford North; Peacehaven North; Newhaven Valley; and Newhaven Denton and Meeching. At the other end of the spectrum, five wards are found in the bottom quartile (least deprived): Newick; Ditchling and Westmeston; Plumpton, Streat et al; Seaford West; and Chailey and Wivelsfield.
- Newhaven Denton and Meeching has an Education, Skills and Training deprivation score of 39.1, which puts it in the top decile for the county. The score for Newhaven Valley is also very high, at 32.1 compared to the East Sussex average of 17.3.
- One in five (21.6%) households are on low income, which is defined as less than 60% of the national median income.
- In Newhaven Denton and Meeching, 50% of adults with learning disabilities are in settled accommodation, which is low compared to the district average of 67%.
- 10.7% of people claim out-of-work benefits.
- Peacehaven East has 6.4% of people aged 16–59 years claiming disability living allowance, compared to 3.8% for Lewes.

- Five per cent of working-age people claim incapacity benefit or severe disablement allowance.
- The 2001 Census showed that 39% of Lewes district households owned their home outright. The lowest was 25% in Newhaven Valley. In Lewes Castle, 23.9% of households rented from a council/local authority. This compared to over 10% in Barcombe and Hamsey, Lewes Bridge, Seaford North, Lewes Priory, Newick and Newhaven Denton and Meeching (roughly double the East Sussex average of 5.4%). In Peacehaven North and Ouse Valley and Ringmer 8.6% and 8% of households, respectively, rented from a housing association/registered social landlord. Seaford Central is in the top decile for the county, with 17.1% of households renting from a private landlord. Ouse Valley and Ringmer and Newhaven Valley also have a high percentage, at 12.5% and 11.2%, respectively.
- Overall, 5.2% of people live in overcrowded households. The rate is double in Newhaven Valley and Seaford Central (10.1% and 10%, respectively). (Census 2001)
- One in 10 (9%) of under-18s live in overcrowded homes. The rate is much higher in Peacehaven East (16% top decile), Lewes Castle, Newhaven Valley and Newhaven Denton and Meeching (all 13%). (Census 2001)
- One in five households (21.3%) have no access to a car or van. (Census 2001)
- Furthermore, 28% of households do not live within 30 minutes of a GP by public transport. This rises significantly for Peacehaven East (47%), Seaford North (43%), Seaford East (40%) and Ouse Valley and Ringmer (42%).
- Peacehaven East has a very high percentage of children travelling to primary school by car/van or taxi (82%, the highest in East Sussex). 38% of secondary school pupils travel to school by car/van or taxi.
- Over one third (34%) of people aged 65 years and over live alone. In Newhaven Valley and Lewes Bridge, this rises to 51% and 50%, respectively. (Census 2001)

Lifestyle and risk factors

- 83% of mothers start breastfeeding, but this falls to 59% at six- to eight-weeks-of-age. In Peacehaven East, only 67% of mothers start breastfeeding. In Peacehaven North, 77% start but only 40% of mothers are still breastfeeding at six- to eight-weeks-of-age. In Newhaven Valley, 70% start, which falls to only 40% of mothers still breastfeeding at six- to eight-weeks-of-age.
- Lewes district has the highest percentage of Reception Year children measured as overweight or obese, at 24% compared to the East Sussex average of 20%. The rate is particularly high in Newick, Peacehaven North, Seaford North and Seaford South (range, 38%–33%; all in the top decile). Lewes district has the second largest percentage of Year 6 pupils classified as overweight or obese, at 30%. Particularly high are Chailey and Wivelsfield (47%; highest in county), Peacehaven North (44%) and Seaford West (43%).
- The estimated level of adult obesity in Lewes district is 22%. Newhaven wards and Peacehaven wards have especially high rates, at 27–26%. In the same areas, there are only 18–19% of adults who participate in sport and active recreation.
- Over one in 10 (13%) mothers are known to smoke at the time of delivery.
- Twenty per cent of adults smoke. One in three adults in Newhaven Valley smoke.
- Teenage pregnancies (30 per 1000 population 15–17-year-olds) are lower than the county average (37 per 1000 population). However, in Lewes Castle and Peacehaven North, the rate is above 60 per 1000 population.

Burden of ill-health

- 78% of people report their health as either good or very good. However, in Peacehaven East, Seaford West and Seaford East, the proportion is much lower.
- There is 18% lower mental illness than the country as a whole. Peacehaven West and Peacehaven East have 27% and 20% more mental illness than the country as a whole. (Mental Illness Needs Index 2000).

Burden of ill-health – mortality

- Life expectancy at birth in Lewes, at 82 years, exceeds the East Sussex average. In Lewes, it ranges from 79 years in Newhaven Valley to 88 years in Kingston (second highest in the county).
- All age, all cause, age-standardised mortality is 10% below the East Sussex average. In Peacehaven East, it is 14% above the average, and 17% above in Plumpton, Streat et al.
- Mortality among people aged 1–19 years (age-standardised) in Peacehaven North and Newhaven Denton and Meeching is 128% and 115% above the county average. However, it should be noted that the numbers are small and cover the years 1999–2007.
- Among under-75s (age-standardised), deaths from circulatory diseases are 12% lower than in the county as a whole. Rates are 28% above average in Peacehaven West.
- Stroke mortality in Lewes is 11% below the East Sussex average. However, rates in Seaford North and Ditchling and Westmeston are 17% and 19% higher, respectively.
- Age-standardised cancer mortality in under-75s is 2% below the East Sussex average. Mortality is 72% above average in Plumpton, Streat et al, 40% higher in Newhaven Valley and 32% higher in Peacehaven North.
- COPD mortality is 9% below the East Sussex average. However, it is significantly higher in Newhaven Valley (96%) and in Plumpton, Streat et al (63%), and 61% lower in Seaford South.
- Mortality from suicide in Seaford Central is almost triple the county average.
- Lewes district has the highest GP-reported chronic kidney disease prevalence, at 44 per 1000 population, compared to the East Sussex average of 37 per 1000 population. This is mainly due to the Seaford wards, which have rates of 72–70 per 1000 population (well within the top decile for the county).
- Reported COPD prevalence varies from 9 per 1000 population in Chailey and Wivelsfield (the lowest rate in East Sussex) to 20 per 1000 population in Peacehaven West and East. The ward average is 15 per 1000 population.
- At 52 per 1000 population, the highest reported prevalence of diabetes mellitus in East Sussex is in Peacehaven West and East. Not far behind are Peacehaven North and East Saltdean and Telscombe Cliffs.
- Reporting of dementia is only, 26% of the expected level.
- Heart failure is reported at only 42% of the expected prevalence.
- The reported prevalence of hypertension is 47% less than expected. It is especially low in Newick, Plumpton, Streat et al, Chailey and Wivelsfield, Barcombe and Hamsey and Lewes Priory. The same wards are very low in terms of the reported prevalence of stroke (around 35–28% less than expected, all in the bottom decile for the county). Newick, Plumpton, Streat et al, Chailey and Wivelsfield, Barcombe and Hamsey and Lewes Priory all have very low levels of GP-reported versus expected hypothyroidism, compared to the rest of county.

Burden of ill-health – primary care

- GP-reported asthma prevalence is very high in Newhaven and Peacehaven wards (all five wards are in the top decile).
- GP-reported prevalence of atrial fibrillation, cancer, CHD, hypertension and stroke or TIA show the Seaford wards (Seaford North, Seaford Central, Seaford East, Seaford South and Seaford West) as having virtually the same prevalence, around the 90th percentile (the hundred percentile is the ward with the highest reported prevalence in East Sussex).

Burden of ill-health – hospital care

- A&E attendances in under-fours are 126 per 1000 population. The East Sussex average is 153 per 1000 population. Rates in Peacehaven West (260 per 1000 population) and Peacehaven East (195 per 1000 population) are well above average.
- Peacehaven West and East also have high rates of admissions for all ages, while the district as a whole is below-average for East Sussex.
- Peacehaven East has the highest rate by far of elective admissions in the county, at 219 per 1000 population for persons aged 1–4 years, compared to the county average of 48 per 1000 population. Peacehaven West has the district's highest emergency hospital admissions among persons aged 1–4 years, at 253 per 1000 population (over double the district average 113 per 1000 population).
- Age-standardised hospital admissions in Lewes are 14% below the East Sussex average, ranging from 64% below average (Plumpton, Streat et al) to 16% above average (Peacehaven East).
- All emergency hospital admissions (age-standardised) are 18% below the East Sussex average, which is the lowest of all local authorities.
- Emergency hospital admissions (age-standardised) due to CHD are 13% lower than the East Sussex average, and range from Chailey and Wivelsfield, at 70% lower than expected, to Barcombe and Hamsey, at 59% more than expected.
- Elective hospital admissions due to atrial fibrillation in Peacehaven West and Seaford South are over double the local authority average.
- Emergency hospital admissions due to COPD are over double the district average of 86 per 1000 population in Newhaven Valley, Peacehaven East and Peacehaven West.
- Peacehaven West has 154% more emergency admissions than expected due to asthma.
- Peacehaven East, Kingston, Seaford South and Lewes Bridge all had between 18% and 78% more emergency admissions due to diabetes than expected.
- In Peacehaven West, emergency admissions due to asthma are the second highest in the county.

Services – social care

- Referrals to adult social care for Lewes district are 36 per 1000 population, rising to 57 per 1000 population in Peacehaven East and 52 per 1000 population in Peacehaven West.
- 15 per 1000 persons aged 18–64 years are supported to live independently through social services, which is below the county average of 18 per 1000 population. It is significantly higher for Peacehaven East, at 28 per 1000 population. For those aged over 65 years, the rate is the highest in East Sussex in Peacehaven West, at 172 per 1000 population. Peacehaven East and Lewes Bridge are close behind, at 172 per 1000 population and 150 per 1000 population, respectively. This compares to 99 per 1000 population for Lewes district and 93 per 1000 population for the county.
- There are high rates for persons aged 18–64 years with physical disability, frailty and sensory impairment, supported to live independently through social services. For Peacehaven East it is 17 per 1000 population (double the county average). The rates are also very high for those aged 65 years and over with Peacehaven East 143 per 1000 population (highest in the county) and Peacehaven West 131 per 1000 population compared with the county average of 88 per 1000 population.

Services – health

- 87% of two-year-olds but only 82% of five-year-olds have received the MMR immunisation.
- Lewes immunisation rate among children aged two years for Pneumococcal infection (PCV) (76%), Haemophilus influenza type b (Hib), meningitis C (MenC) - (Hib/MenC) (86%) and MMR (87%) are all lower rates than in other districts.
- The five Seaford wards (Seaford North, Seaford Central, Seaford East, Seaford South and Seaford West) all have low cervical screening uptake, at 78% of eligible women versus the district average of 81%.

Services – children's services

- In Lewes, 9.8% of pupils receive free school meals. This is higher in the most deprived wards of Newhaven and Peacehaven. Newhaven Valley has the highest, at 19.3%, followed by 16% for Peacehaven North.
- Peacehaven West has the highest rate (75.7 per 1000 population) of pupils with English as an additional language, compared with the county average of just 22.4 per 1000 population.
- Newhaven Valley, Newhaven Denton and Meeching and Peacehaven East had the lowest assessments for Foundation Stage, ranging from 60% to 64.6%, compared to the district average of 81.5%, achieving at least 78 points.
- The highest rate of children with an allocated social worker in Lewes was for the Newhaven wards.

User perspectives on services

- In Lewes, 69% of people said they were satisfied with telephone access to their GP surgery, compared to 71% of people across East Sussex. Respondents from Seaford East, Seaford South, Newick, Seaford North and Chailey and Wivelsfield reported low satisfaction (range 60%–62%).
- Newhaven and Peacehaven wards had a low percentage of respondents able to see their preferred doctor always, almost always or a lot of the time (in the low 70s compared to the East Sussex average of 84%).
- 35% of older people in Lewes said they received the support they need to live independently at home, which is slightly higher than the East Sussex average (32%).

Demography

- Rother is the second smallest populated district in the county, with an estimated 88,813 people.
- The highest fertility rate in Rother is found in Bexhill Central ward, at 88 per 1000 population, with Bexhill Sidley close behind, at 86 per 1000 population. The lowest is found in Bexhill Collington, at just 27 per 1000 population.
- Salehurst, Darwell and Ticehurst and Etchingham have the highest percentage of total population aged 5–14 years in Rother (14.9% and 14.1%, respectively), both in the top decile for the county. This contrasts with Bexhill Sackville and Bexhill Collington, which are in the bottom decile in the county (4.7% and 6.3%, respectively).
- In Rother, 28.1% of total population is aged 65 years and over, the highest proportion in the county. The ward with the highest percentage is Bexhill Sackville, at 44.8% (the highest in East Sussex), followed by Bexhill Collington (43.6%), Bexhill Kewhurst (38.1%) and Bexhill St Marks (35%) (all in the top decile for the county). This compares to the East Sussex average of 22.6%.
- The Rother district projected percentage increase in population from the 2008 baseline follows the East Sussex average, at 2.1% by 2011 and 3.4% by 2013 (2.1% and 3.5%, respectively for the East Sussex average). Rother closely follows the East Sussex projected changes across all age ranges. There is expected to be minimal changes among those aged 0–64 years, with an increase of just 0.7% by 2011 and a decrease of 0.7% by 2013. For those aged 65 years and over, there is projected a change of 5.6% by 2011 and 12.4% (16.1% among males and 9.7% among females) by 2013.
- The county has less diversity in terms of ethnicity and religion compared to England's average. In East Sussex, only 2.3% of people are of non-White ethnicity and 1.3% belong to a main religion other than Christianity, compared to 5.5% and 8.7%, respectively, for England. In Rother, the figures are 1.9% and 1.1%, respectively.

Social/environmental context

- Rother is the third most deprived district in East Sussex. The most deprived ward is Bexhill Sidley, which is in the top decile in East Sussex, at a score of 34.37, compared with the county average of 18.78. Bexhill Central, Eastern Rother, Bexhill Sackville, Rye and Bexhill St Michaels wards are all in the top quartile (most deprived 75–100%) for the county. It should be noted that the Index of Multiple Deprivation is calculated nationally for LSOAs, which are smaller than wards. Thus, Bexhill Sidley ward is made up of four LSOAs, two of which are in the top 20% ranked nationally and one in the top 30% most deprived nationally. Bexhill Central has three LSOAs, one in the top 20% and two in the top 30%. Eastern Rother has two LSOAs in the top 30%, while Bexhill Sackville and Rye have one LSOA in the top 30% deprived LSOAs nationally. The least deprived ward is Bexhill St Marks, with a score of just 7.70.
- One in four (25.8%) households are on a low income, which is defined as less than 60% of the national median income.
- One in eight (12.5%) of the Rother population claim out-of-work benefits. In Bexhill Sidley, this rises to one in four (25.9%), with Bexhill Central just behind at 23.8%.
- The percentage of working age people claiming incapacity benefit or severe disablement allowance is 7%. This figure increases in the more deprived wards.
- The 2001 Census showed that 45% of Rother households owned their home outright. This is the highest proportion in East Sussex and compares with the county average of 38%. Bexhill Collington, Bexhill St Marks, Bexhill Kewhurst and Marsham have some of the highest home ownership rates in the county, ranging from 66% to 59%. Rother has a very low percentage of households rented from council/local authority, at only 1.9% versus the county average of 5.4%. The exception is Bexhill Sidley, at 8%. Rother has the highest proportion of households rented from a housing association/registered social landlord versus the other districts, at 8.7%. Bexhill Sidley, at 24.7%, has by far the largest rate in Rother, followed by Rye, at 15.1%. In Bexhill

- Central, 29% of households are rented from a private landlord, while 8.1% of households Eastern Rother are rented from Other (the largest in the county).
- Only 4.2% of people live in overcrowded households (11.5% in Bexhill Central), with 8% of under-18s living in overcrowded homes. (Census 2001)
- One in five households (20.8%) have no access to a car or van, rising to 44.9% in Bexhill Central ward. (Census 2001)
- One in three (32%) older people aged 65 years and over live alone. This rises to one in two (49%) in Bexhill Central.
- Three in four primary school children travel to school by car/van or taxi in Marsham and Bexhill Collington wards, compared to one in two children in Rother. Two in five secondary school pupils travel to school by car/van or taxi in Bexhill Collington and Bexhill St Marks, compared to one in five for the district as a whole.

Lifestyle and risk factors

- 77% of mothers in Rother start breastfeeding, but this falls to 48% at six- to eight-weeks-of-age. In Eastern Rother, Bexhill Sidley and Rye only 55% and 59% of mothers, respectively, start breastfeeding. In Bexhill St Marks, 96% of mothers start breastfeeding, although this drops to 59% at six to eight weeks. In Rye, only 22% of mothers are breastfeeding at six to eight weeks, and the percentage is only 25% in Bexhill Sidley.
16% of Reception Year children are classified as overweight or obese, compared to 20% for the county. Marsham, Bexhill Collington and Eastern Rother have much higher rates, with 33% of Year 6 children overweight or obese (East Sussex average, 28%). Rye ward has the highest rate, at 45%, followed closely by Rother Levels, Marsham, Bexhill Kewhurst and Battle Town. 21% of adults are estimated to be obese and only one in five (20%) adults participate in sport and active recreation.
- One in five mothers (19%) are known to smoke at the time of delivery. In Bexhill Sidley, this figure is 42%. 18% of adults smoke in Rother, which is relatively low compared to the East Sussex average of 23%. There is quite a range for Rother wards from 13–28%.

- Teenage pregnancies (35 per 1000 population of 15–17-year-olds) are lower than the county average (37 per 1000 population). However, this is much higher in Bexhill Sidley with 81 per 1000 population.

Burden of ill-health

- In Bexhill Sidley, 11% of births were classified as low birthweight (under 2,500 grams). This is the highest in the county.
- Rother has a Mental Illness Needs Index (2000) of 0.79, which suggest 21% lower rates of illness compared to the country as a whole. However, there are high indices for some areas. Bexhill Central has an index of 2.08, which suggest 108% more illnesses severe enough to need hospital treatment from time to time among people aged 16–59 years. Bexhill Sidley and Bexhill Sackville have an index of 1.37 and 1.36, respectively, (or 37% and 36% more illness severe enough to need hospital treatment from time to time).
- The Index of Common Mental Illness identifies 11.4% of the population in Rother aged 16–64 years as suffering from a range of neurotic symptoms. This is a little lower than the county average of 12.8%. One ward, Bexhill Central, has rate of 15.4% (top decile in the county). This same ward also has 8% of people aged 16–64 years suffering symptoms of depression, compared with 6.4% for Rother.

Burden of ill-health – mortality

- Life expectancy at birth in Rother, at 82 (range, 79–85 years), exceeds the East Sussex average.
- All age, all cause, age-standardised mortality is 2% above the East Sussex average. In Darwell, the rate is 40% above the county average. Old Town (Bexhill), Ewhurst and Sedlescombe, and Crowhurst are all in the top quartile for the county, ranging from 21% to 29% above the average.
- Mortality from causes ‘amenable to health-care’ is 75% higher in Bexhill Central, and 62% higher in Bexhill Sidley compared to East Sussex as a whole.
- Among people aged 1–19 years, mortality in Rother Levels is double, and Ticehurst and Etchingham triple, the county average.

- Among under-75s, deaths from circulatory diseases are 75% higher in Bexhill Central, and 70% higher in Bexhill Sidley, than in the county as a whole.
- Age-standardised stroke mortality is high for Darwell and Bexhill Sidley (62% and 53% above the East Sussex average).
- COPD mortality in Darwell is 46% greater than in East Sussex as a whole.
- Bexhill Sidley and Bexhill Central have the highest rates in Rother, at 62% and 75% above the county average for mortality from causes considered amenable to healthcare.
- Mortality rates from suicide in Bexhill Old Town and Sackville are double the county average.

Burden of ill-health – primary care

- Rother is above the 75th percentile for GP-reported cancer, at 17% compared to the county average of 14%. Bexhill St Marks has the highest recorded prevalence in East Sussex (21 per 1000 population).
- There is a similar pattern of GP reported prevalence for atrial fibrillation, CHD, dementia, heart failure and stroke. The prevalence for Rother is above the 75th percentile (in the 90th percentile or above for heart failure). Bexhill Sidley, Bexhill Central, Bexhill Sackville, Bexhill St Michaels, Old Town (Bexhill), Bexhill St Stephens and the three least deprived wards – Bexhill Collington, Bexhill Kewhurst and Bexhill St Marks – are all in the top decile (exceed the 90th percentile) for the county.
- Bexhill St Marks ward has the highest reported dementia prevalence in East Sussex, at 13 per 1000 population. However, this is still 60% less than the predicted prevalence.
- Reported prevalence of heart failure in Rother is 13 per 1000 population, compared to 9 per 1000 population in East Sussex as a whole.

Burden of ill-health – hospital care

- The rate of A&E attendances in under-fours is 151 per 1000 population. The rate is above 200 per 1000 population in Bexhill St Michaels and Bexhill St Stephens. The rate is only 73 per 1000 population from the Rother Levels.

- There are 6% fewer A&E attendances (age-standardised) in Rother than the average across East Sussex. Bexhill Sidley attendances are 26% higher than the average.
- Ewhurst and Sedlescombe has the highest rate of emergency admissions among children aged 5–9 years in the county: 155 per 1000 population. This compares to the average of 47 per 1000 population).
- Bexhill Sackville, Bexhill St Stephens, Bexhill Sidley, Marsham, Bexhill St Michaels and Crowhurst are all in the top decile for the county for the rate of emergency hospital admissions for persons aged 10–19 years (between 91 per 1000 population and 72 per 1000 population).
- Old Town (Bexhill), Eastern Rother, Bexhill Sackville, Bexhill St Michaels and Bexhill Sidley are all in the top decile in East Sussex for emergency hospital admissions due to infections for person aged 0–4 years.
- Admissions in childhood (under 18) due to injuries (unintentional and deliberate) are the highest in Rother compared to the other districts, at 221 per 10,000 population, compared to the county average of 166 per 10,000 population. Marsham, Bexhill Sidley and Bexhill St Stephens are all almost twice the county level.
- Emergency (age-standardised) admissions for circulatory diseases are 15% above the county average, but vary from 42% below in Salehurst to 68% above in Ewhurst and Sedlescombe.
- Emergency CHD admissions are 63% above the county average in Bexhill Sidley and 41% above the average in Kewhurst. Rother is 15% above that of the county.
- Total cancer admissions in Rother are 20% greater than the county average. In Bexhill Sidley emergency admissions due to cancer are 80% above the county average (the highest in East Sussex).
- Emergency stroke admissions in the East Rother ward are the highest in East Sussex, at 87% above the average.
- Rother average emergency COPD admissions are 11% below the county average. However, Bexhill Sidley has admissions 93% above East Sussex average.
- Emergency admissions due to diabetes are three and half times the county average in Ewhurst and Sedlescombe.

- Emergency admissions due to mental illness are 5% below the average for East Sussex. In Bexhill Central, the rate is almost three times and in Bexhill Sackville double this level. Eastern Rother has 121% more hip replacements than the county average.

Services – social care

- Referrals to adult social care are 43 per 1000 population, rising to 66 per 1000 population at Bexhill Sackville, 59 per 1000 population at Old Town (Bexhill) and 58 per 1000 population at Bexhill St Marks.
- 19 per 1000 persons aged 18–64 years are supported to live independently through social services, just above the county average of 18 per 1000 population. The rate is significantly higher for Bexhill Sidley and Bexhill Central, at 42 per 1000 population and 36 per 1000 population. For those aged over 65 years, the rate is high in Bexhill Sidley, at 122 per 1000 population, compared to 79 per 1000 population for Rother.
- There are high rates for persons aged 18–64 years with physical disability, frailty and sensory impairment supported to live independently through social services in Bexhill Sidley, at 21 per 1000 population (the highest in the county). The rates are also high among those aged 65 years and over again in Bexhill Sidley, at 109 per 1000 population, compared with 78 per 1000 population for Rother.

Services – health

- Only 88% of two-year-olds, and 75% of five-year-olds have received the MMR immunisation. The rate is particularly low for two-year-olds in East Rother, at 76% and Ticehurst and Etchingham, at 75%. Uptake is very low among five-year-olds in Ticehurst and Etchingham, at 40% (lowest in the county), Salehurst (47%), Darwell (63%) and Bexhill St Marks (68%).
- The immunisation rate among children aged five years against Diphtheria, Tetanus, Polio, Pertussis is 78%; the lowest uptake amongst the districts. Particularly low are Ticehurst and Etchingham, at 44% (the lowest in the county), Salehurst (51%), Darwell (63%) and Bexhill St Marks (76%).

- There are high rates of young people aged 0–18 years in drug or alcohol treatment in Old Town (Bexhill), Bexhill Central and Bexhill St Michaels. The rates remain high among adult clients aged 19 years and over in drug treatment in Old Town (Bexhill) with 83 per 10,000 population.

Services – children's services

- In Rother, 11.2% of pupils receive free school meals. The rate is higher in the most deprived wards, at 28.9% in Bexhill Sidley, 17% in Bexhill Central and 14.5% in Eastern Rother.
- Bexhill Sackville has the highest rate (107.5 per 1000 population) of pupils who have English as an additional language, compared with the county average of just 21.9 per 1000 population.
- Marsham had the lowest assessments for the Foundation Stage, with only 52.6% achieving at least 78 points compared to the district average of 78.7%. Bexhill St Michaels, Bexhill Sidley and Bexhill Sackville were also below 70%. Only 32% and 36.8% of children at Bexhill Sackville and Marsham, respectively, achieved at least 78 points overall and 6+ points in all Personal, Social and Emotional Development and Communication, Language and Literacy assessments in the foundation stage.
- The highest rate of children with an allocated social worker for Rother is in Bexhill Sidley, at 43 per 1000 population.

User perspectives on services

- In Rother, 77% of respondents were satisfied with telephone access to their GP surgery but only 63% were satisfied in Ewhurst and Sedlescombe and 67% in Brede Valley.
- 34% of older people said they received the support they need to live independently at home in Rother (2% above the county average). In Crowhurst, only 16% said they got the support they needed. This contrasts with Bexhill Sidley, where 53% were satisfied, the highest percentage in East Sussex.

Demography

- Wealden is the most populated district, with an estimated 145,882 people. The next largest district is Eastbourne, with 97,691 people.
- The highest fertility rate in Wealden is found at Polegate North and Hailsham East, both with 88 per 1000 population. Forest Row has the lowest rate, at 24 per 1000 population (the lowest in East Sussex), followed closely by Crowborough St Johns at 25 per 1000 population.
- Hailsham East, with 7.5% of its population aged 0–5 years, has the district's highest percentage, followed by Crowborough Jarvis Brook, Hailsham South and West and Uckfield Ridgewood, at 6.9–6.8%.
- Forest Row, Uckfield Ridgewood and Hailsham East are all in the county's top decile with 16.8%, 16.7% and 16.3% of their population, respectively, aged 5–14 years. This compares with the county average of 11.3%.
- An estimated 10.5% of the population in Mayfield is aged 15–19 years (the highest in the county). In contrast, the rate East Dean is only 3.4%; the lowest in the county.
- Uckfield Ridgewood, Crowborough Jarvis Brook and Crowborough East are all in the county's top decile, with 86.7%, 86.6% and 86% of their population, respectively, aged 0–64 years.
- In Polegate South, 38% of the population is aged 65 years and over (the highest in Wealden). Close behind are: Alfriston, with 34%; Willingdon, with 32.1%; and Polegate North, with 31.6%. This contrasts with the Wealden average of 21.9%.
- The Wealden district projected percentage increase in population from the 2008 baseline is 1.6% in 2011 and 3.1% in 2013, which is just below the East Sussex average of 2.1% and 3.5%, respectively. The population is predicted to slightly decline among 0–19-year-olds and 0–64-year-olds, by less than 1%. However, there is expected to be a significant increase among those aged 65 years and over. A 7.5% increase is predicted by 2011 and a 15.6% increase by 2013. This is the highest predicted increase of all the districts and appears to be focused on those aged 65–84-years, with only a 4.1% increase predicted for those aged 85 years and over by 2013.

- The county has less diversity in terms of ethnicity and religion compared to England. Only 2.3% of the East Sussex population is from a non-White ethnicity and 1.3% belong to a main religion other than Christianity, compared to 5.5% and 8.7%, respectively, in England as a whole. Wealden is the least diverse district, at 1.7% (highest: Mayfield, 4.3%; and Forest Row, 3.4%) and 0.9%, respectively.
- Hellingly, Polegate North and Uckfield Ridgewood had the highest percentage of household commitments (potential new houses), at 42%, 36% and 26% of existing households. This compares to the district average of 7%.

Social/environmental context

- Wealden is the least deprived district in East Sussex, with a score of 10.98, compared with the county average of 18.78. The most deprived ward is Hailsham East, which is in the top decile in East Sussex with a score of 30.98. The next most deprived ward is Hailsham South and West, at 18.62, which is just below the county average. Wealden has the least deprived ward in the county, Uckfield Ridgewood, with a score of just 2.59. Seven of the 35 wards in Wealden are in the least deprived decile for the county, and 18 out of 35 are in the least deprived quartile. It should be noted that the Index of Multiple Deprivation is calculated nationally at the level of LSOAs, which are smaller areas than wards. Therefore, Hailsham East is made up of two LSOAs, both of which are in the top 30% ranked nationally. The only other ward to have LSOAs in the top 30% most deprived nationally is Hailsham South and West, which is made up of five LSOAs, one of which is in the 20% most deprived LSOAs in England and one that is in the top 30% most deprived. The other three LSOAs that make up Hailsham South and West are less deprived, and ranked between 70–90% nationally. This accounts for it being less deprived than Hailsham East.
- One in five (19.5%) households are on a low income, which is defined as less than 60% of the national median income. This is the lowest of the districts. However, Hailsham East has the highest percentage of households on low income in East Sussex, at 38.4%.

- Chiddingly and East Hoathly, Crowborough West and Buxted and Maresfield have a low percentage (28%) of persons aged 18–64 years with learning disabilities in settled accommodation. This compares with the county average of 63%.
- Out-of-work benefits are claimed by 7.4% of people. Again, the distribution is uneven, with 21.5% claiming in Hailsham East. The second highest rate is 13.7%, in Polegate South.
- 4% of working-age people claim incapacity benefit or severe disablement allowance.
- The 2001 Census showed that 41% of households own their house outright. This rose in Alfriston to 63%, 57% in East Dean and 56% in Willingdon. 42% of Wealden households have a mortgage or loan. The highest proportion in East Sussex is 65% in Uckfield Ridgewood. In Wealden, 5.3% of households are rented from a council/local authority (county average 6.4%). In a few wards, this is significantly higher. Hailsham East has a rate of 35.3% (highest in East Sussex), while Crowborough Jarvis Brook has a rate of 16.9% and Polegate South a rate of 12.2%. Hailsham South and West and Hailsham East had 9.6% and 6.8% of its households, respectively, rented from a housing association/registered social landlord, compared to the district average of just 2.5%.
- Overall, 3.4% live in overcrowded households, with 6% of under-18s in overcrowded homes. In Hailsham East, these figures are 10% and 19%, respectively. (Census 2001)
- One in six households (14.1%) have no access to a car or van. (Census 2001)
- One third of those (31%) aged 65 years and over lives alone. (Census 2001)
- One in every two primary children in Wealden travels to primary school by car/van or taxi. This is significantly higher in the Crowborough wards (Crowborough St Johns, 83%; Crowborough West, 79%; Crowborough Jarvis Brook, 74%; and Crowborough East, 73%). Among secondary school pupils, this reduces to 16% travelling to school by car/van or taxi. However, the percentages in Heathfield East and Heathfield North and Central are 51% and 40%, respectively.

Lifestyle and risk factors

- 83% of mothers start breastfeeding, but this falls to 59% at six- to eight-weeks-of-age. In Hailsham East, the rate of uptake is only 50% (falling to 27% at six to eight weeks), the lowest in East Sussex. Hailsham South and West and Hailsham North and Central are also low, with initiation rates of 66% falling to 36% and 43%, respectively, at six to eight weeks. This compares to 100% after six to eight weeks in Polegate South and East Dean, where status is known.
- 18% of Wealden Reception Year children are overweight or obese. This compares to 20% for East Sussex. However, Crowborough Jarvis Brooke and Polegate North have rates of 33% and 31%, respectively, which places them in the top decile for the county. 14% of Year 6 children are classified as obese, which compares with 15% for East Sussex as a whole. However, Framfield, Ninfield and Hooe, Warling, Pevensey and Westham, Polegate North, Hailsham East and Uckfield New Town have high rate, at 27%, 26%, 24%, 23%, 23% and 23%, respectively. Among adults, 21% are estimated to be obese and only one in five (22%) adults participate in sport and active recreation.
- The teenage pregnancy rate in Wealden is 24 per 1000 population for 15–17-year-olds, which is lower than the county average (37 per 1000 population). In all Hailsham wards, the teenage pregnancy rate exceeds 48 per 1000 population.
- Over one in ten (12%) mothers are known to smoke at the time of delivery. This rate is substantially higher in Hailsham East, at 31%, and Hailsham South and West, at 26%.
- 18% of adults smoke; however, in Hailsham East, the rate is 31%.

Burden of ill-health

- Heathfield East, Framfield, East Dean and Crowborough East are all in the top decile in East Sussex, with 10% of births classified as low birth weight (under 2,500 grams).
- Overall, 79% of people report their health as either good or very good. However, rates in Uckfield Central Alfriston, Polegate North and especially Hailsham East were much lower, while, at the other extreme, 100% of people report their health as either good or very good in Heathfield East.
- Wealden has a Mental Illness Needs Index (2000) of 0.62, which suggest that there is 38% lower illness in the area compared with the country as a whole. However, there are high indices for Hailsham East, at 1.21, which suggests 21% more illnesses severe enough to need hospital treatment from time to time for people aged 16--59 years. Hailsham East is also slightly above average in terms of the incidence of common mental disorders such as neurotic symptoms and depression.

Burden of ill-health – mortality

- Life expectancy at birth in Wealden, at 83 years, exceeds the East Sussex average. This ranges from 79 years in Danehill/Fletching/Nutley to 89 years in Crowborough Jarvis Brook .
- All age, all cause, age-standardised mortality is 6% below the East Sussex average. It is significantly higher in Danehill/Fletching/Nutley (50%), Chiddingfold and East Hoathly (30%) and Hellingly (30%).
- Mortality among people aged 1–19 years was very high in Hellingly, at 194% greater than expected, although it should be borne in mind that the numbers for this indicator are small.
- Stroke mortality (age-standardised) is only 2% above East Sussex average in Wealden. In Uckfield Ridgewood, stroke deaths occur at over twice this rate, at 120% above the average. In addition, Danehill/Fletching/Nutley, Hailsham East and Hellingly are all in the top decile for the county, with rates of 71%, 55% and 51%, respectively, above the county average.
- Age-standardised cancer mortality in under-75s is 11% below the East Sussex average.

- COPD mortality is 13% below the East Sussex average. However, there are some wards with high levels of mortality. In Hailsham East, the rate is over double the country average (123% above). Chiddingfold and East Hoathly and Ninfield and Hooe, Wartling also have high mortality rates, at 96% and 76%, respectively, above what would be expected.
- Mortality from causes considered amenable to healthcare is 10% below the East Sussex average. Hailsham East (61%), Hellingly (49%) and Uckfield New Town (47%) are all above the county average, however, and are in the top decile.
- Mortality from suicide in East Dean ward is double the district average and 70% above the county average.

Burden of ill-health – primary care

- At 72 per 1000 population, Polegate South has the highest recorded prevalence of asthma in East Sussex. Polegate North and Hailsham East follow closely behind, at 71 per 1000 population, and just behind them are Hailsham South and West and Willingdon, with rates of 69 per 1000 population. At the other extreme, Forest Row has the lowest rate in the county, at just 46 per 1000 population.
- Polegate North and Polegate South have a very high reported chronic kidney disease prevalence of 82% and 78%, respectively, more than double Wealden's average of 35%.
- Reported COPD prevalence varies from 9 per 1000 population in Uckfield North (the lowest rate in East Sussex) to 26 per 1000 population in Polegate South (the highest rate in East Sussex, with Polegate North just below, with 25 per 1000 population). The district and county average is 15 per 1000 population.
- Polegate North and South also have the highest recorded rates of hypertension in East Sussex, at 216 per 1000 population and 214 per 1000 population, respectively, and the highest rate in the district for hypothyroidism (60 per 1000 population and 58 per 1000 population, respectively) and stroke or TIA at 36 per 1000 population in both.
- Reporting of dementia is only at 33% of the expected level.

- Heart failure is reported at only 39% of the expected prevalence.
- The reported prevalence of hypertension is 47% less than expected.

Burden of ill-health – hospital care

- A&E attendances in under-fours are 105 per 1000 population. The East Sussex average is 153 per 1000 population. The rates in Hailsham East (227 per 1000 population) and Polegate North (173 per 1000 population) are well above this.
- Wealden's A&E attendances are below the county average for all age ranges, with Hailsham East having above average rates in all cases. Thus, all age (age-standardised) A&E attendances are 17% below the East Sussex average. The range is from 49% below average (Uckfield Ridgewood) to 38% above average (Hailsham East).
- Emergency hospital admissions due to symptoms and signs without definite diagnosis for persons aged 0–4 years are very high for Polegate South, at 89 per 1000 population, the highest in East Sussex.
- Age-standardised admission rates are 4% below the East Sussex average (range, 39% fewer admissions than expected in Forest Row to 35% above in Hailsham East).
- Emergency admissions due to asthma in children in Alfriston are 10 per 1000 population, the highest in East Sussex.
- Admissions (age-standardised) for circulatory disease in Uckfield New Town are 57% greater than the East Sussex average (the highest rate in East Sussex). Admission rates are also very high in Newhaven and Polegate wards.
- Admissions due to CHD are 59% greater than the county average in Hailsham East and 99% higher in Uckfield New Town (the highest in the county). Uckfield New Town also has 114% more emergency admissions than expected due to CHD, this is also the highest in the county.
- Admissions due to cancer (age-standardised) are 12% below the county average. In Uckfield Central they are 47% above average. Emergency cancer admissions in Ninfield and Hooe, Wartling are 65% above the East Sussex average.

Hailsham East (267% more than expected) has the highest age-standardised emergency admission rate for asthma in East Sussex, over three and a half times the East Sussex average. Hailsham Central and North also has 205% more than expected and Alfriston has 109% more than the county average.

Services – social care

Referral rates to adult social care are 31 per 1000 population in Wealden, rising to 46 per 1000 population in both Polegate North and Alfriston.

Fourteen per 1000 persons aged 18–64 years are supported to live independently through social services, which is below the county average of 18 per 1000 population. The rate is significantly higher for Hailsham East, at 39 per 1000 population. For those aged over 65 years, the rate is high in Uckfield New Town and Uckfield Central, at 157 per 1000 population and 138 per 1000 population, compared to the district average of 83 per 1000 population.

There are high rates of persons aged 18–64 years with physical disability, frailty and sensory impairment supported to live independently through social services in Hailsham East, at 19 per 1000 population (over double the county average of 6 per 1000 population), and Hailsham South and West, at 11 per 1000 population. The rates are also very high among those aged 65 years and over in the Hailsham wards, at 116 per 1000 population for both, compared with the county average of 88 per 1000 population.

Services – health

89% of two-year-olds and 84% of five-year-olds have received the MMR immunisation. Only 60% of two-year-olds in Forest Row, and 62% in Heathfield East, have received the vaccine.

Immunisation rates for children aged two years against Pneumococcal infection (PCV) are 86% above the county average in Wealden. However, four wards are particularly low: Forest Row, 51%; Alfriston, 56%; and Framfield, Heathfield East, 62%.

- There are high rates for young people aged 0–18 years in drug or alcohol treatment in Hailsham South and West, at 59 per 10,000 population, compared to the district average of 17 per 10,000 population.
- Forest Row has the lowest cervical screening uptake of just 72% of eligible women. This is the lowest in East Sussex. Danehill/Fletching/Nutley and Hartfield also have low uptakes. The breast screening uptake for eligible women in Wealden is 75%, compared to 70% for East Sussex. All wards meet the county average, apart from Forest Row, Hartfield and East Dean.
- Pneumococcal vaccination coverage is 68% for Wealden, below the county average of 70%. Particularly low rates are seen in Polegate North, Forest Row, Polegate South, Willingdon, Herstmonceux, Danehill/Fletching/Nutley and Horation, which are all in the bottom decile for the county, at less than 65% coverage.

Services – children’s services

- Wealden has 5.5% of pupils receiving free school meals. This is half the county average. Only Hailsham East is significantly higher than the county average, at 18.4%.
- Wealden district has the lowest rate (18.8 per 1000 population) amongst the districts of pupils with English as an additional language, which compares to the county average of 35.8 per 1000 population. Only Uckfield New Town, Uckfield North and Polegate North have rates slightly above the East Sussex average (range 47.5–38.9 per 1000 population).
- 14 per 1000 population of children have an allocated social worker in Wealden, less than the county average of 24 per 1000 population. Hailsham East is the only ward with a significantly higher rate, at 64 per 1000 population.

User perspectives on services

- Overall, 94% of respondents were satisfied with the care received at their GP surgery. For Mayfield, the rate was just 90%, and the Hailsham wards (Hailsham East, Hailsham South and West and Hailsham Central and North) had a rate of only 91%.
- In Wealden, 72% of people said they were satisfied with telephone access to their GP surgery, compared to 71% for East Sussex. Less satisfaction was reported in Uckfield Central (57%), Uckfield North (58%) and Uckfield New Town (59%).
- In Wealden, 91% of respondents were able to see a doctor fairly quickly over last 6 months. This was lower in respondents from Uckfield Central, Uckfield North, Uckfield New Town, Crowborough West, Crowborough North, Crowborough St Johns and Wadhurst (range, 85%–87%, all within the bottom decile for the county).
- In all, 31% of older people in Wealden said they received the support they need to live independently at home (just below the East Sussex average of 32%). However Crowborough (14%), Danehill/Fletching/Nutley (17%), Hartfield, Forest Row and Herstmonceux (20%) were well below the average.

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. The comprehensive needs assessments on Black and Minority Ethnic Groups and Offender Health are the most recently completed, and are briefly discussed here. Other comprehensive needs assessments have informed sections in Chapter 3 of this report, e.g. children, older people and alcohol.

Black and Minority Ethnic Groups (BME)

To better understand the needs of BME a Comprehensive Needs Assessment for Black and Minority Ethnic Groups (including Gypsies and Travellers) was commissioned in 2009.

East Sussex has a relatively small BME population compared to the rest of the South East and with England. In East Sussex, 2001 Census data indicates that 94.4% of the population described themselves as White British, compared with 92.2% in the South East as a whole. However, the breakdown of ethnicity across East Sussex at the district and borough level suggests a more complex picture. BME population estimates indicate that the White Irish and White Other populations more than doubled between 2001 and 2007, with BME

groups including White Irish and White Other forming around 10% of the population in Eastbourne and Hastings (Table 13).

The BME population in East Sussex is expected to continue to rise over the next ten years, with projections suggesting that the population of people from 'All Asian' and 'Asian British' and 'All Black' and 'Black British' people will increase by more than 400% by 2020 (Table 14).

The age structure of the population in East Sussex varies by ethnic group. All BME populations in East Sussex have a smaller proportion of people aged over 65 years compared with 'All White', and 'All Mixed' populations, which have markedly higher numbers of young people. This has potential implications for delivery of services to these population groups over time (Figure 44).

Health of BME communities

There are a number of ways in which ethnicity can have an impact on health. The determinants of health may differ between ethnic groups; for example, through genetic differences, population structures, culture and socioeconomic factors. There is evidence that racial inequalities persist in the UK, and the combined impact of lower job status, unemployment and poor and overcrowded living conditions are important when looking at ethnic differences in health. Racism (whether direct in the form of racist abuse or indirect via structural discrimination) can also have an impact.

The major concerns of the ethnic minority populations were found to be the same as for the rest of the population (CHD, stroke, cancer, diabetes). What may be different are the belief systems, attitudes to health and life and ability to access services.

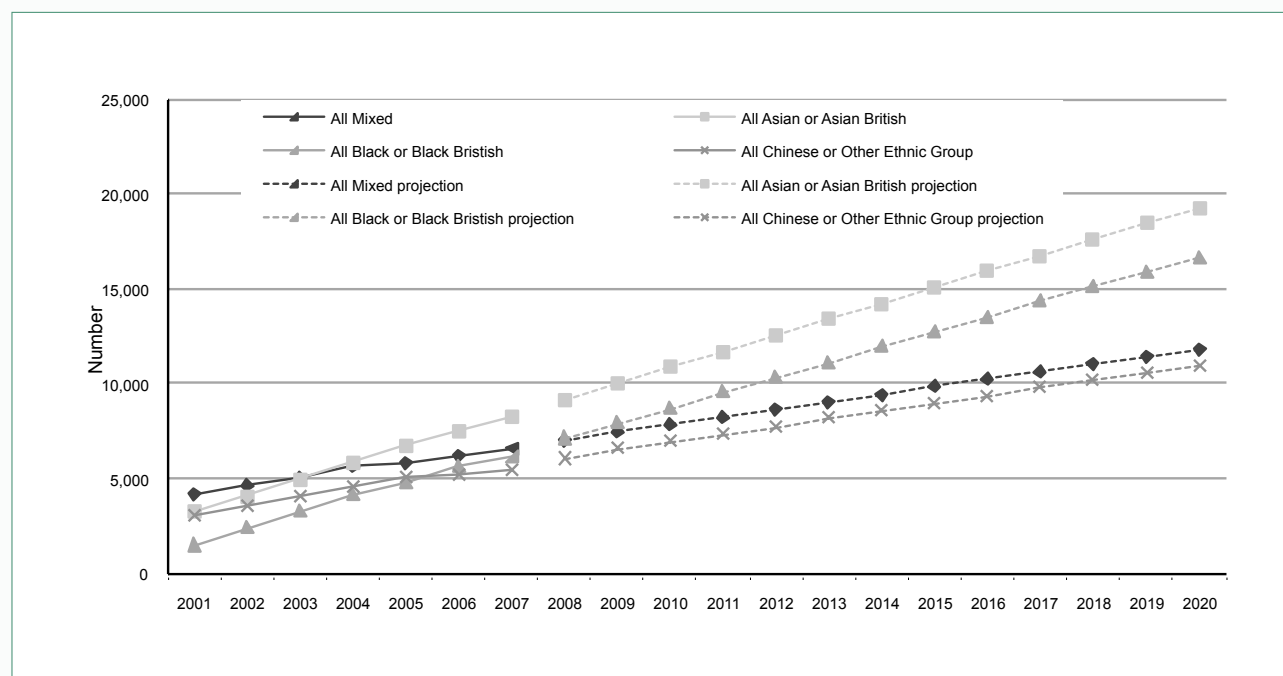
2 / What is the Health Inequalities Gap in East Sussex?

Table 13: *Numbers and percentages of the black and minority ethnic populations by local authority, 2001 and 2007, ONS*

Ethnic groups	2001				2007			
	BME		BME inc White Irish and White other		BME		BME inc White Irish and White other	
	Number	%	Number	%	Number	%	Number	%
Hastings	2,500	2.9	5,100	6.0	5,200	5.0	9,600	10.0
Rother	1,600	1.9	3,900	4.6	3,500	4.0	6,400	7.3
East-bourne	2,900	3.2	6,700	7.5	5,900	6.2	9,900	10.4
Lewes	1,900	2.1	4,400	4.8	4,600	4.9	8,100	8.6
Wealden	2,300	1.6	5,700	4.8	6,100	4.2	11,500	8.0
East Sussex	12,000	2.4	27,600	5.6	26,500	5.2	45,700	9.0
South East	400,200	5.0	707,400	8.8	661,200	8.0	1,062,300	12.8
England	4,552,800	9.2	6,523,900	13.2	6,009,100	11.8	8,355,900	16.4

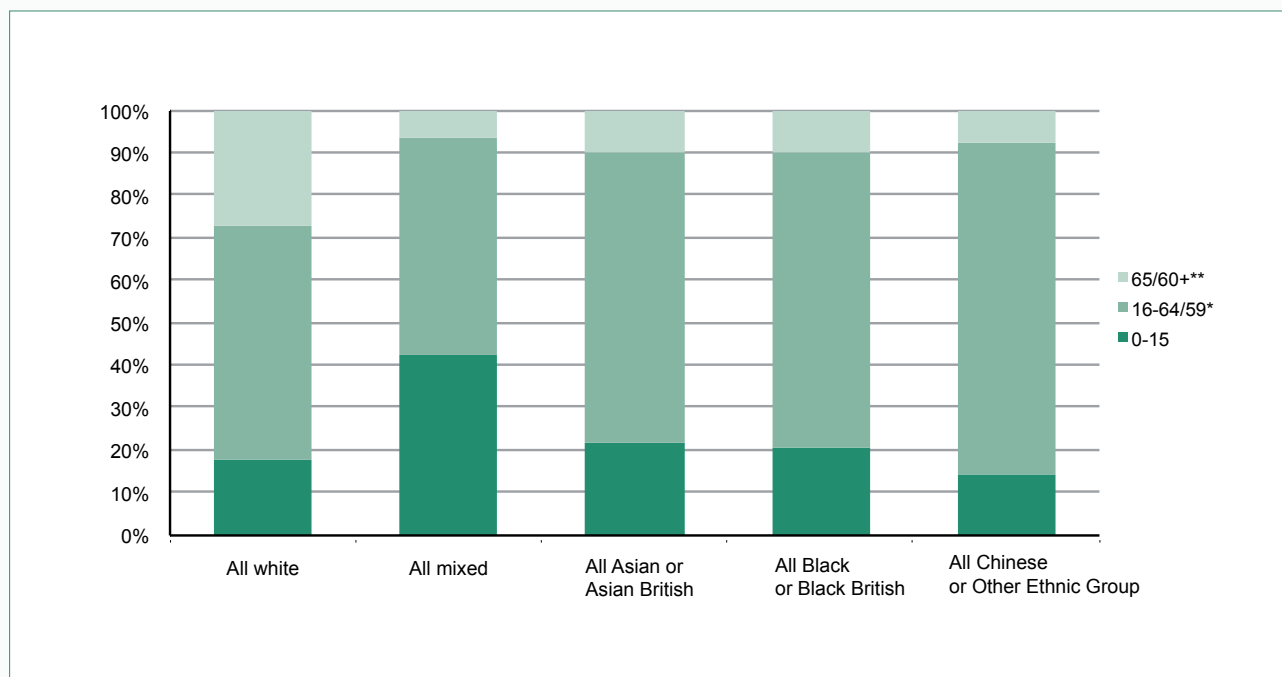
Source: Office of National Statistics

Figure 43: *Projection of black and minority ethnic groups in East Sussex to 2020*



Source: ONS

Figure 44: Age structure of ethnic groups in East Sussex, 2007



Source: ONS

*16–64 for males; 16–59 for females.

**65 and over for males; 60 and over for females

Table 14: Summary of relative frequency of diseases in black and minority ethnic groups compared with the majority population

Diseases that are common in one or more black and minority ethnic group	Less common	Uncertain frequency
Infectious diseases including TB and Malaria	Diseases of the nervous system	Mental disorders
Diabetes		
Perinatal mortality		
Hypertension and stroke		
Liver and prostate		
Haemoglobinopathies		
Vitamin D deficiency		

2 / What is the Health Inequalities Gap in East Sussex?

Gypsy and traveller health

The BME Comprehensive Needs Assessment found that a number of studies reported significantly poorer health and more self-reported symptoms of ill health in gypsy and traveller populations compared with other UK residents, English speaking ethnic minorities and economically disadvantaged White UK residents. For gypsies and travellers, living in a house is associated with long term illness, poorer health state and anxiety. The poorest health is in those who travel rarely. Health inequality between gypsies and travellers and the UK general population is significant. Reported health care problems are between twice and five times more prevalent than in the wider population. Chest pain, respiratory problems and arthritis are more prevalent in the traveller group. There is also an excess prevalence of miscarriages, stillbirths, neonatal deaths and premature death of older offspring. Ill health can be seen as normal, and stoically and fatalistically accepted.

Self reported health and wellbeing

According to the Health Survey for England (HSE), a number of BME are more likely to report that they have a longstanding limiting illness (an illness or disability that has affected them over a period of time), in particular Pakistani (women) and Bangladeshi (men). On the other hand, Chinese men and women, and Black African men were less likely to report a longstanding limiting illness.

Access to health care services

Access to high quality primary care services is an important element to addressing health inequalities.

The number of international in-migrants registering with a NHS GP in East Sussex is captured through the Patient Register Data Service (PRDS). The Office of National Statistics (ONS) releases this dataset, formally named 'Flag 4'. A Flag 4 is generated when an individual registers with an NHS GP if:

- An individual was born outside the UK and enters the England and Wales for the first time and registers with NHS GP; or

- If the previous address of an individual is reported as outside the United Kingdom, and the time spent outside the UK is more than 3 months.

The trend in numbers of international in-migrants registering with a GP, by district councils, increased, with the highest number registering in Eastbourne since 2001 (Figure 45). Despite the steady increase in number of international migrants in Lewes, this is not reflected in GP registrations.

Secondary care

Data from Hospital Episode Statistics for the period 1st April 2006 to 31st March 2009 suggests that rates of admission for elective and emergencies procedures are significantly higher in BME populations. The reason for this is unclear; however, it may reflect additional need and/or lack of use of primary care services.

Lifestyle and BME

Smoking

The Health Survey for England 2004 found that Bangladeshi men were considerably more likely to report smoking than the general population.

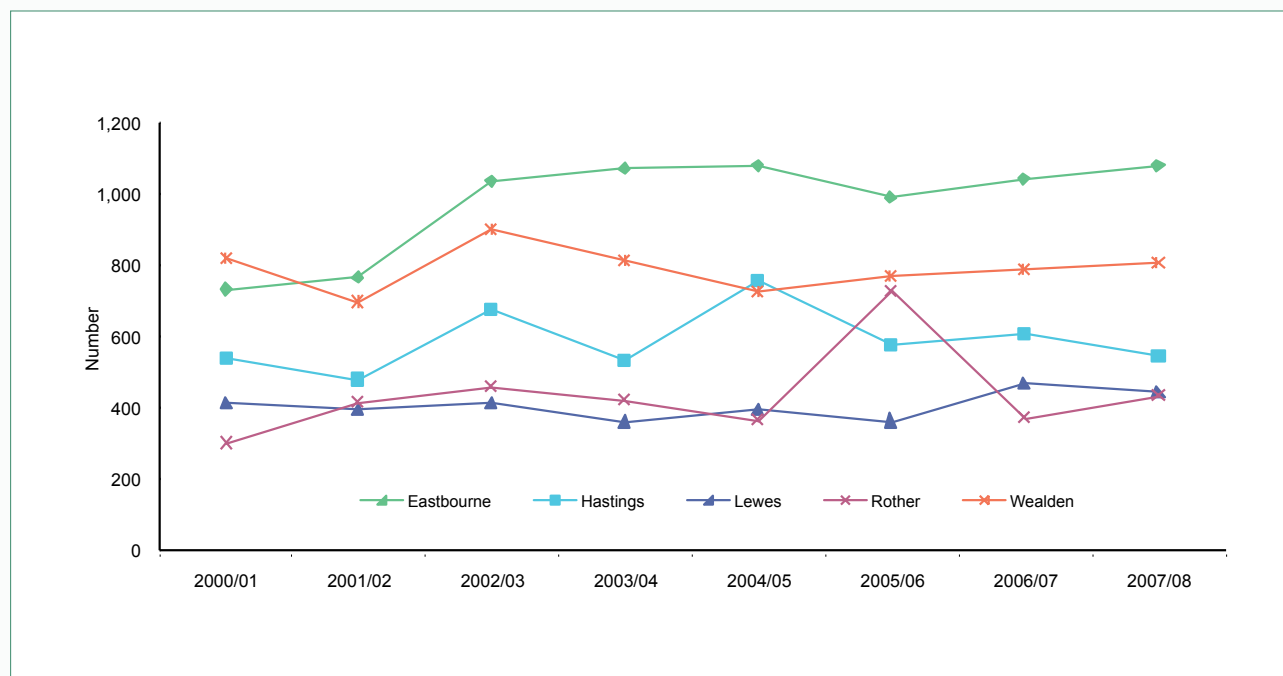
Obesity

The HSE 2004 found that obesity rates were generally higher amongst females, with women from the Black African and Black Caribbean groups much more likely to be obese. Most at risk of a high waist circumference were Pakistani men, Black Caribbean women, Black African women, Pakistani women, Bangladeshi women. The least likely to have a raised waist circumference were Bangladeshi men and Chinese men and women.

Alcohol

In the general population surveyed in 2004, 18% of men and 10% of women said that they drank alcohol almost every day. The black and minority ethnic community reported drinking less frequently than the general population, apart from the Irish, who drank as often. The EU accession country data (Data Appendix Table 10) show that only Hungary and the Czech Republic consume more alcohol per capita than the UK.

Figure 45: International in-migrant GP registrations, East Sussex districts and boroughs, 2000/01–2007/08



Source: ONS

Activity levels

National data from the HSE 2004 indicates that, after age standardising, Indian, Pakistani, Bangladeshi and Chinese populations were less likely to meet the recommended levels of physical activity.

Fruit and vegetable consumption

Overall, BME populations consumed more fruit and vegetables. Chinese and Indian populations are particularly more likely to eat five daily portions than the general population.

Implications for statutory organisations

Growing populations and different age structures may have implications for the provision of health and social care services, either due to the different prevalence of diseases or because of cultural differences in access to healthcare services.

A full copy of the BME (including gypsies and travellers) needs assessment is available on both PCT websites (www.esdw.nhs.uk) and (www.hastingsrother.nhs.uk).

Offender Health

A comprehensive needs assessment focusing on offender health has recently been completed.

East Sussex has a sizeable offender population of 500 prisoners housed in HMP Lewes at any one time. This figure will rise to 750 in 2011, with over 1,000 offenders managed in the community.

Offenders tend to have significantly poorer health than the general population. There is a high prevalence of mental health problems, dyslexia, learning disability and restricted mobility amongst offenders.

The prison population, who may be on short sentences, includes a significant proportion of individuals who have no fixed abode.

Offenders often smoke and have health problems relating to the harmful use of drugs and alcohol.

Around 90% of inmates have at least one mental health problem and this can be exacerbated by the prison experience. Poor mental health may also lead to neglect of physical wellbeing.

2 / What is the Health Inequalities Gap in East Sussex?

There is a higher prevalence of chronic diseases, such as epilepsy, asthma and cardiovascular disease, among prisoners than the general population.

Certain groups of prisoners have particular needs and health problems, in particular those with learning disability and learning difficulties, women, older people, BME and young offenders. These groups tend to come from more deprived backgrounds and have poorer health.

The national plan for improving offender health Improving Health, Supporting Justice was published in November 2009. This was a joint initiative between the Department of Health, Department of Children, Schools and Families, Ministry of Justice, Youth Justice Board and the Home Office. Between them, these government departments/agencies have responsibility for health, social care and all the component services within the criminal justice system.

Developing commissioning and local delivery through partnership working, workforce development, better performance management, training and improved access for offenders with mental health, learning disabilities, substance and alcohol are all key themes of the plan.

Prison health promotion

Lewes Prison has a series of programmes in place to check and address the health needs of prisoners. Primary care services are provided within the prison and aim to be of the same standard as those in the community.

Promotion of health begins on reception into the prison, and every new prisoner receives a full health screening on their first night. Referrals on to, for example, mental health services, the stop smoking service, chronic disease clinics, sexual health services and the over 55's clinic are all made at this time. These services can then be accessed throughout the sentence.

A high proportion of prisoners have drug problems. Of all new receptions to HMP Lewes last year (2009/10), 32.8% were assessed as needing treatment for substance misuse problems. Over a ten-month period, 228 inmates started treatment.

Currently, East Sussex Stop Smoking services provide a weekly one-to-one smoking cessation support service to both inmates and members of staff. Engagement is high, and around six out of ten prisoners who access the service will go on to achieve their 4-week quit.

Services that can help address underlying causes of ill health are, for example, aimed at housing and money advice.

The prison education service aims to support the development of skills that may help to improve job prospects and increase confidence. A range of courses are provided including: BICS (industrial cleaning), Bricklaying, CSCS (relates to the building site operatives card and covers safety issues), First Aid, Horticulture, Food Preparation and Cooking, Food safety, Painting and Decorating, and programmes to support preparation for release.

Given the high levels of mental health problems among the prison population, promoting mental wellbeing is important. Initiatives underway include Samaritans' support for 'listeners'. Listeners are inmates trained in peer-support, and there are 13 listeners in the prison at present.

Maintaining links between a prisoner and their family can be important for promoting mental health. In the initiative 'Storybook Dads', men are encouraged to read and record bedtime stories to their children.

There is an accredited cognitive behaviour therapy course called CALM (Controlling your Anger and Learning how to Manage It). This is made up of 20 sessions, and there are 16 places available per year. A victim awareness course called 'Sycamore Tree', which has 48 places per year, is also run.

A full copy of the Offender Health needs assessment is available on both PCT websites (www.esdw.nhs.uk) and (www.hastingsrother.nhs.uk).

Focused Work on Increasing Life Expectancy

Specific inequalities work was undertaken that focused on the 20 wards with the lowest life expectancy across East Sussex and aimed at improving life expectancy and reducing the gap in life expectancy was undertaken. This led to the Investing in Life Programme.

Investing in Life programme

The population of East Sussex is generally healthy in comparison to other areas in England. On average, men and women in East Sussex expect to live longer than in England as a whole. However, there are large differences in life expectancy at local authority and ward level. Therefore, the PCTs declared a strategic aim of reducing the life expectancy gap between the 20 wards with the lowest life expectancy across East Sussex compared to rest of East Sussex. Table 15 below details those 20 wards.

To reduce the life expectancy gap, the PCTs committed to a new initiative – the ‘Investing in Life’ programme – that aims to tackle vascular disease. Action needed to be focused on preventing early deaths of people who already had the disease or were at high risk, so the programme focused on smoking cessation, increased statin prescribing, cardiovascular risk registers and the implementation of relevant National Service Frameworks (Renal, Coronary Heart Disease, Diabetes, Stroke Strategy).

Later, the programme was extended to include reducing infant mortality, as it makes a considerable contribution to lower life expectancy. Action needed to focus on the three main causes of infant mortality: immaturity related conditions, congenital anomalies and sudden unexplained death. A reduction in infant mortality is achieved through a combination of NHS interventions and actions on the wider determinants of health. Reducing smoking in pregnancy, reducing the number of women sharing a bed with their baby or putting their baby to sleep in the prone position, achieving the teenage pregnancy targets, increasing breastfeeding, improving maternal diet, antenatal and neonatal screening and improved immunisation uptake all have a benefit in reducing mortality for children aged under 1 year.

2 / What is the Health Inequalities Gap in East Sussex?

Table 15: *The 20 wards with the lowest life expectancy in East Sussex, 2003–2005*

Ranked wards in order of increasing life expectancy (2003/05)	Local authority area	Life expectancy (persons, yrs)
Central St Leonards	Hastings	72.1
Sackville	Rother	74.9
Maze Hill	Hastings	75.5
Gensing	Hastings	75.7
St Michaels	Rother	75.9
Sidley	Rother	76.2
Devonshire	Eastbourne	77.0
Hailsham East	Wealden	77.3
Peacehaven East	Lewes	77.4
Wishing tree	Hastings	77.4
Hampden Park	Eastbourne	77.7
Ore	Hastings	77.8
Braybrooke	Hastings	78.1
Seaford Central	Lewes	78.2
Old Town (Bexhill)	Rother	78.2
Uckfield New Town	Wealden	78.4
Peacehaven West	Lewes	78.6
Upperton	Eastbourne	78.6
Hellingly	Wealden	78.7
Hollington	Hastings	78.9
East Sussex (excluding the 20% of wards with the lowest life expectancy)		81.1

Source: Deaths occurring in the 3 years 2003, 2004 and 2005.

The Programme has established targets aimed at increasing life expectancy both in the 20 wards and the rest of East Sussex, and also a target on reducing the life expectancy gap. The table below presents these three targets and progress to date. All three targets are performing well and are ahead of target.

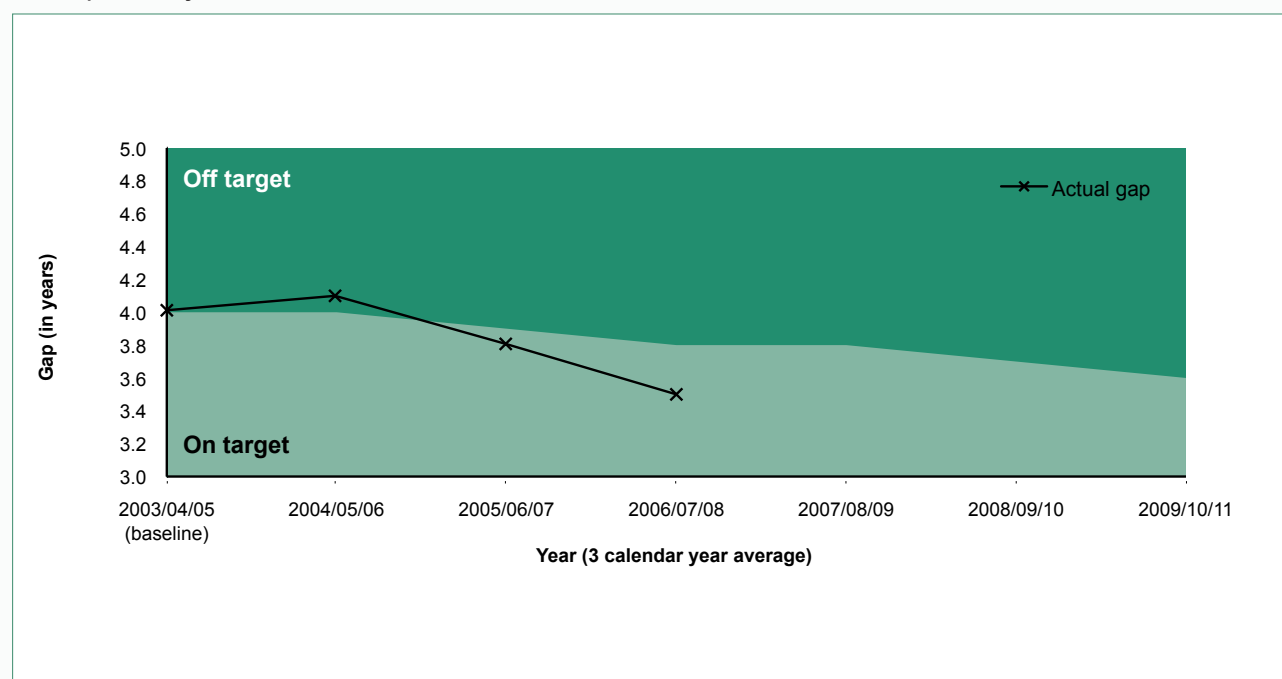
The life expectancy gap, in particular, is reducing, and has reduced from 4 years to 3.5 years, as shown in the diagram on the right (Figure 46).

We know that people living in more deprived areas will, on average, die earlier than people living in more affluent areas. To what extent, therefore, are the Investing in Life areas the most deprived areas? Thirty four of the 73 (47%) LSOAs within the Investing in Life wards are identified as being in the most deprived (bottom) quintile in East Sussex, according to the IMD 2007.

Table 16: Investing in Life Programme targets, progress to date

	2003 / 04 / 05	2004 / 05 / 06	2005 / 06 / 07	2006 / 07 / 08	2007 / 08 / 09	2008 / 09 / 10	2009 / 10 / 11
TARGET Life expectancy in the 20 priority wards (years)	77.0	77.4	77.7	78.1	78.4	78.8	79.1
ACTUAL Life expectancy in the 20 priority wards (years)	77.0	77.5	78.2	78.6	Data not yet available		
TARGET Life expectancy in the remainder (wards)	81.1	81.3	81.6	81.9	82.2	82.5	82.8
ACTUAL expectancy in the remainder (wards)	81.1	81.6	82.0	82.1	Data not yet available		
TARGET Life expectancy gap	4.0	4.0	3.9	3.8	3.8	3.7	3.6
ACTUAL Life expectancy gap	4.0	4.1	3.8	3.5	Data not yet available		

Figure 46: Life expectancy gap in East Sussex between wards with the lowest life expectancy at birth and the rest, 2003/04/05–2009/10/11



Source: ONS

2 / What is the Health Inequalities Gap in East Sussex?

Table 17: *Deprivation category for the LSOAs within the Investing in Life wards*

Investing in Life wards		Deprivation quintile for LSOAs within each ward			
District / borough	Ward name	Bottom	Neither	Top	Grand total
Eastbourne	Devonshire	5	2		7
	Hampden Park	4	3		7
	Upperton	2	4		6
Hastings	Braybrooke	2	1		3
	Central St Leonards	4			4
	Gensing	3	1		4
	Hollington	4			4
	Maze Hill	1	2		3
	Ore	1	2		3
	Wishing Tree	2	1		3
Lewes	Peacehaven East		3		3
	Peacehaven West		3		3
	Seaford Central		2	1	3
Rother	Bexhill Old Town		3		3
	Sackville	1	2		3
	Sidley	3	1		4
	St Michaels		3		3
Wealden	Hailsham East	2			2
	Hellingly		3		3
	Uckfield New Town		1	1	2
Grand total		34	37	2	73
		47%	51%	3%	100%

The table above shows the deprivation category for the LSOAs that sit within the 20 Investing in Life wards.

The table shows that, while deprivation does play a significant part, it is not the only reason. Other factors do play a part, including the presence of care homes with older residents.

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 abstract geometric shapes. A large, solid green shape occupies the bottom half of the frame. Above it, a lighter green, semi-transparent shape overlaps, creating a layered effect. The top portion of the slide is a solid light blue color.

Promoting Healthy Lifestyles

Increasingly, the diseases people experience are linked to lifestyle choices such as smoking, exercise, diet and alcohol consumption. However, the choices people make are influenced by their circumstances, with income, education and environmental factors playing a major part. All partners across East Sussex have an important role in supporting people to make healthy choices, and addressing the barriers that 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.

In 2004, the White Paper *Choosing Health, Making Healthy Choices Easier* set out the key principles for supporting the public to make healthier and more informed choices over their health. This identified five priority topic areas – sexual health, mental health, tobacco control, diet and physical activity and alcohol – in which lifestyle changes would make a difference to health and contribute to tackling health inequalities. In response, local action plans for delivering the five priority topic areas were developed and these have underpinned commissioning for health improvement in recent years.

By working together, partners across East Sussex can improve the health of local people and reduce the difference in health outcomes between groups and communities. In recent years, there has been much research and national guidance on what works in relation to improving and promoting health, and this evidence of effectiveness should underpin all local work to improve health.

The following chapter sets out the local approach to promoting health for the five priority topic areas. In addition to the detailed recommendations set out in the Choosing Health White Paper, the most recent policy guidance, evidence and best practice that underpin the current approach are identified.

Alcohol

Background

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. Alcohol-related deaths have increased and, although the number of offences related to alcohol use has generally decreased, people think that alcohol-related offences are more of a problem than the health consequence. Research suggests that this is a misconception.⁸

The harm to the individual from drinking alcohol can be acute or chronic. There are 46 medical conditions that are caused by or strongly associated with alcohol consumption. These include alcoholic liver disease, alcohol poisoning, stroke, heart disease, cancers and behavioural disorders. Hospital admissions directly related and attributable to alcohol are rising nationally by around 80,000 every year, comprising 6% of all NHS hospital admissions. Deaths from liver disease are now occurring at much younger ages than had previously been seen.

Reducing the rate of hospital admissions due to alcohol-related harm is a new measure of performance for the NHS. A national indicator is now in place to measure changes in the rate of hospital admissions for alcohol related conditions.

In addition to its impact on health care services, alcohol-related harm has an impact on agencies, communities, families and individuals across East Sussex. Figure 47 indicates the costs across communities associated with alcohol misuse.

Alcohol in East Sussex

Alcohol takes a huge toll on all communities, East Sussex included. Its impact on the lives of individuals, families, communities and health services is described in the recently published Comprehensive Needs Assessment Assessing and Addressing the Harms Caused by Alcohol to Individuals and Communities in East Sussex.⁹ In this needs assessment, the cost to the health service alone of alcohol-related harm in East Sussex is estimated to be approximately £14 million per annum. Across East Sussex, there are marked patterns of alcohol use and harm across East Sussex. While 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.

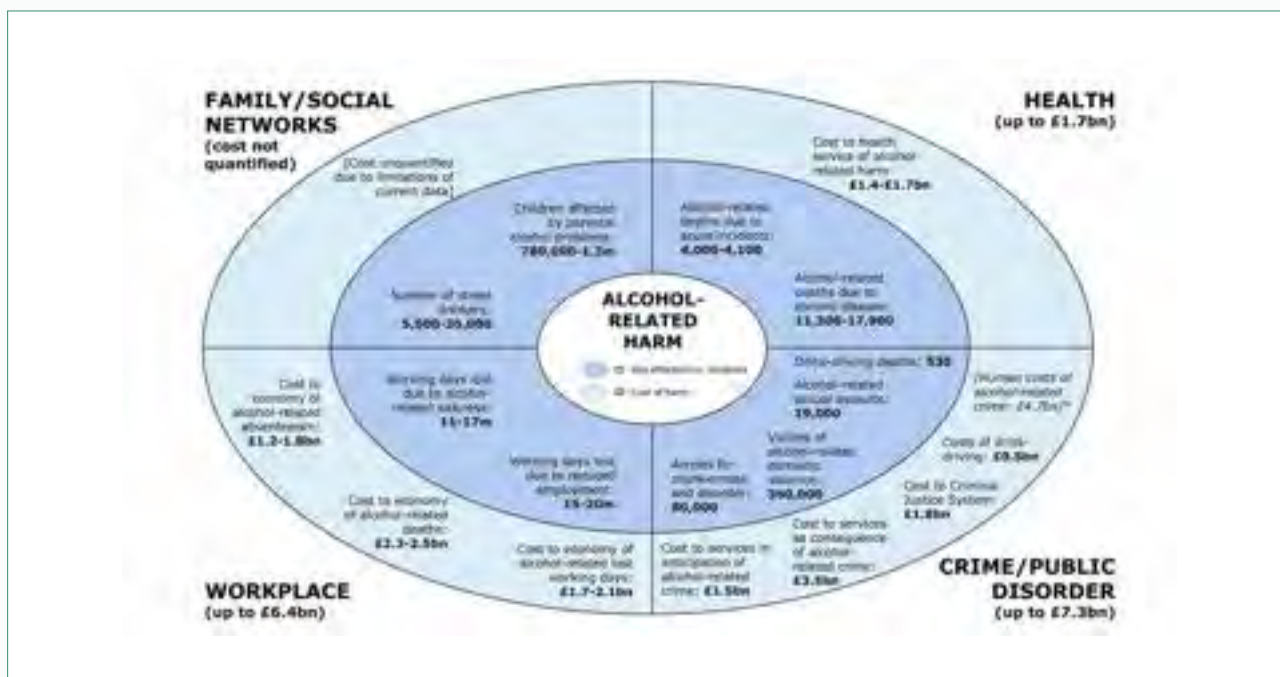
Alcohol issues are particularly marked in Hastings and Eastbourne, which have some of the highest rankings in the country for a number of alcohol-related indicators. Eastbourne ranks as the third highest area nationally for alcohol-associated months of life lost. Hastings ranks 9th highest nationally for alcohol-related hospital admissions for men. Across all alcohol related indicators, nine of Eastbourne's and 10 of Hastings' rankings are among the top 50 in the country. Conversely, seven of Wealden's rankings are among the lowest 50 in the country.

Data from the South East Coast Ambulance Service confirm the picture of differential rates of problems associated with alcohol use across the county and reflects the pattern found in the North West Public Health Observatory's modelling, which suggests higher rates of problems in coastal areas. Eastbourne has twice the rate (34 per 1000 population) of alcohol related responses than that of Wealden (17 per 1000 population).

⁸ *Safe, Sensible Social: the next steps in the alcohol strategy 2007*. Department of Health, 2007.

⁹ *Assessing and addressing the harms caused by alcohol to individuals and communities in East Sussex*. NHS East Sussex Downs and Weald and NHS Hastings and Rother, 2009.

Figure 47: Costs across communities associated with alcohol misuse



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

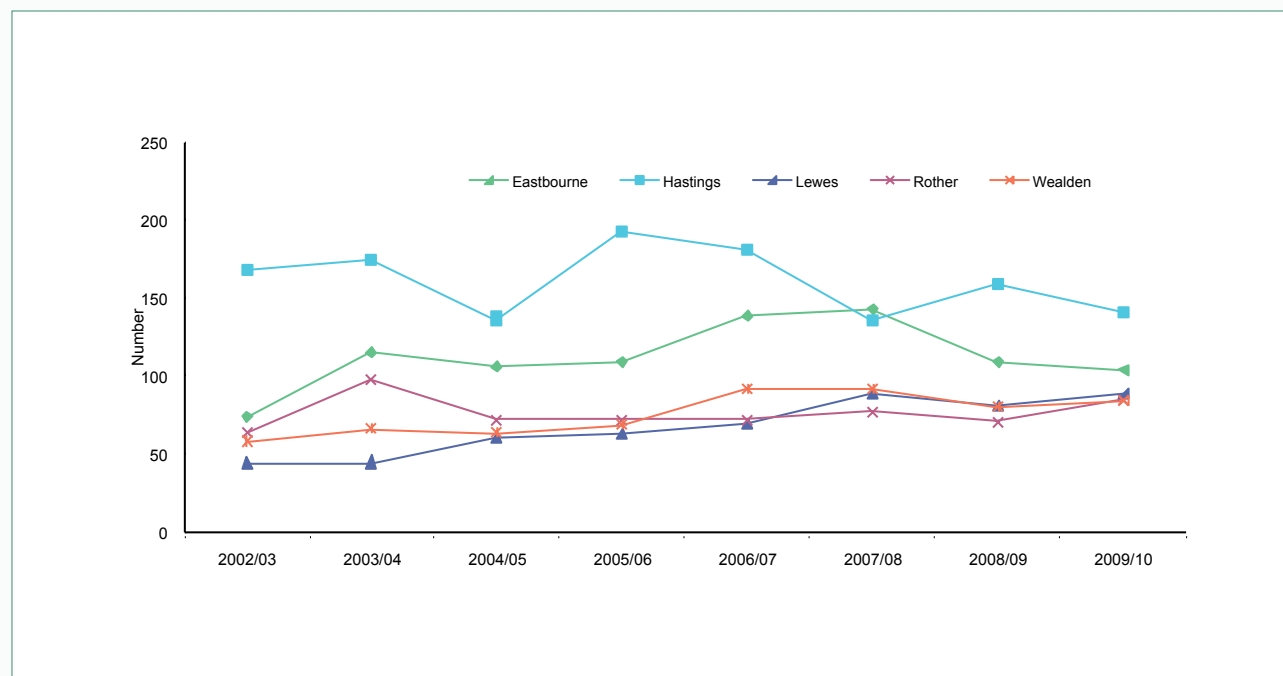
This highlights two key factors that need to be taken into account when planning any response to alcohol misuse in the county:

- 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.

The number of hospital admissions directly attributable to alcohol for East Sussex local authorities for 2002/03 to 2009/10 is shown in Figure 48. Hastings has the highest number of admissions, followed by Eastbourne

3 / How are we tackling Health Inequalities?

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



Source: SUS hospital episode extracts

Tackling underage drinking

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. Nearly half of all 10–17-year-olds who drink once a week or more admitted to some sort of criminal or disorderly behaviour, and the number of hospital admissions related to alcohol consumption has been increasing among young people in England in recent years.

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. A total of 149 per 100,000 population aged under 18 years were admitted to hospital due to alcohol in 2005/6 to 2007/8. This is compared to 60 per 100,000 population in Wealden.

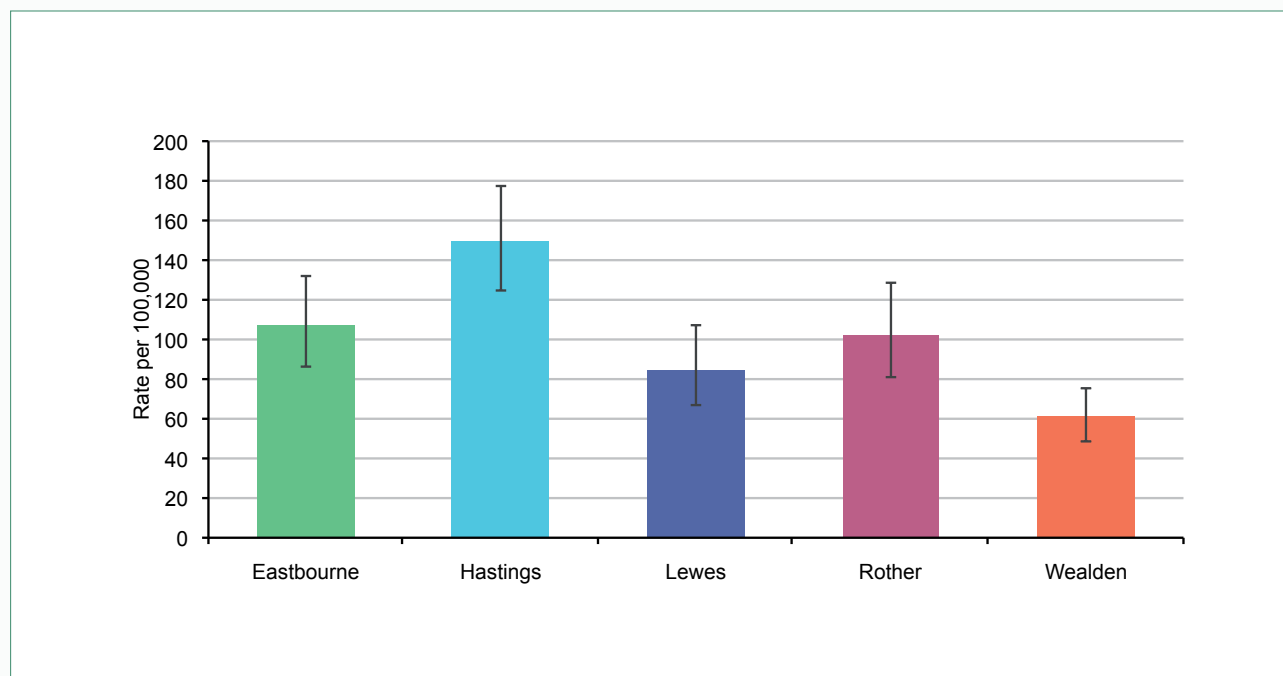
Rates of alcohol use are strongly linked to levels of deprivation and this is reflected in Figure 49. It is worrying that the alcohol-consumption habits of young people appear to be leading to the need for hospital care, and this is especially so in Hastings, which has the highest rate.

Alcohol problems among older people

People over 65 drink significantly less than younger age groups. However, demographic data suggest that the number of people over 65 with alcohol problems will grow over time. East Sussex has a population over 65 that is above the national average and trends suggest that this number will increase.

Although there are no convincing data to suggest that alcohol problems among older people are a key local issue, the growth of the over 65 population suggests that this is an area that merits further exploration.

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

Choosing Health Action Plans 2009/10

The East Sussex Choosing Health Alcohol Strategy 2008/2011 sets out the PCTs' and partners' approach to improving health through tackling alcohol. Its accompanying action plan sets out specific actions to contribute to a delivery system that effectively prioritises and delivers action on alcohol misuse, building capacity and re-orienting health services.¹⁰

Two key areas of the 2009/10 Choosing Health Action Plan for alcohol harm reduction 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, A&E 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.¹¹

2. Promote 'safer 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.¹²

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

¹⁰ Ottawa Charter for Health Promotion; World Health Organisation, 1987.

¹¹ *Safe, Sensible, Social: The next steps in the national alcohol strategy.* Department of Health, August 2007.

¹² <http://www.drinking.nhs.uk>

Activity in East Sussex

The PCTs and partners have worked together through the East Sussex Safer Communities Partnership to develop and deliver key interventions to reduce the number of increasing risk and higher risk drinkers across the county. Key interventions include:

Identification and Brief Advice Training

Training to ensure that key professionals across agencies are skilled and able to deliver Identification and Brief Advice. Key settings that are being targeted include A&E departments, primary care and services supporting offenders; e.g. probation.

Social marketing and campaigns

Development of an East Sussex Communication and Social Marketing action plan for alcohol to ensure that campaigns and messages are joined up. Future priorities will include ensuring that information is available in suitable formats for 16-19-year-olds, and 18–24-year-old binge drinkers.

‘Safer Pubbing’ projects, especially in Eastbourne and Hastings, and the delivery of ‘Safe Space’ in Eastbourne, all of which were key ‘Night Time Economy’ initiatives.

Smoking and Tobacco Control

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 society.¹³ 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.¹³ Figure 50 shows the death rate from smoking among people aged over 35 years. This shows that, while East Sussex has a lower death rate than England, Hastings has a higher rate.

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 a Local Area Agreement (LAA) target and through the Local Strategic Partnerships (LSPs), which 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).

Smoking prevalence

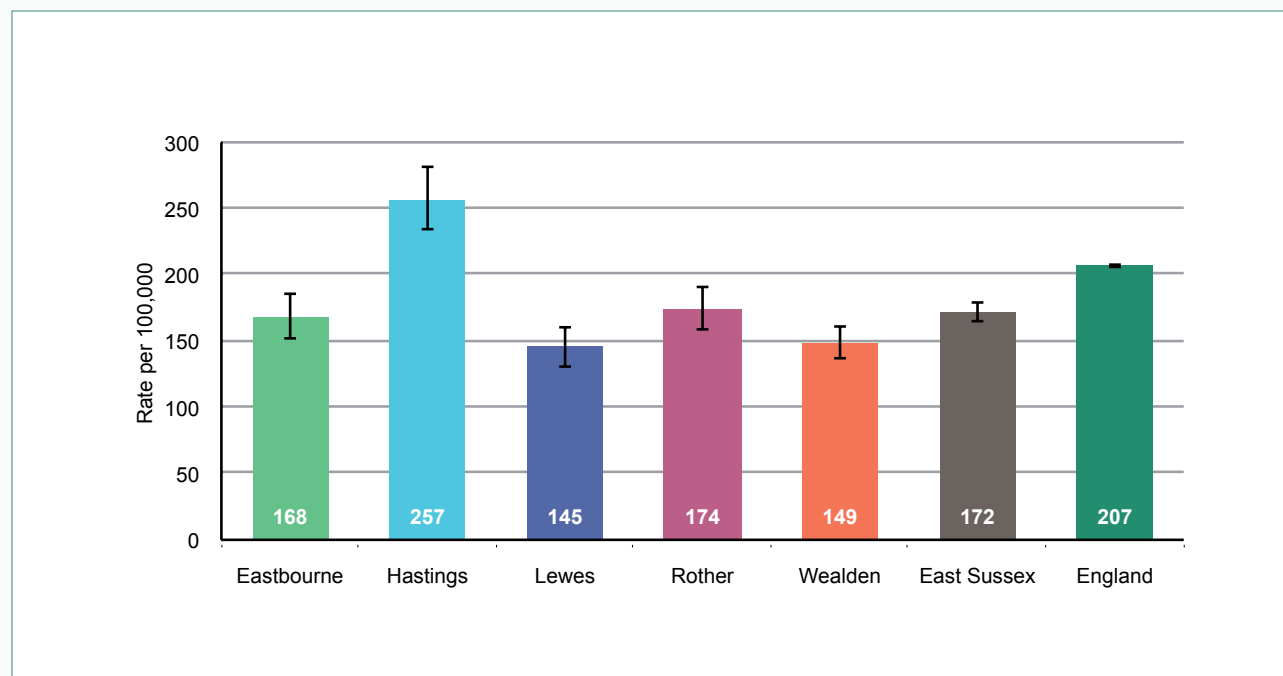
Smoking prevalence across East Sussex varies between wards (Figure 51), and is strongly linked to deprivation. Nationally, smoking prevalence in the highest income quintile is almost half that of smoking prevalence in the lowest income quintile.

Across East Sussex, around 24% 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 recorded as having a prevalence of over 40%. There is a strong correlation between wards with higher rates of smoking and those with lowest life expectancy.

¹³ *A Smoke free Future, A comprehensive Tobacco Control Strategy for England.* Department of Health, February 2010.

3 / How are we tackling Health Inequalities?

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

National strategy

Smoking is a complex behaviour and the factors which influence smoking are multifaceted. Figure 52 sets out the range of influences on smoking behaviour for individuals and societies.

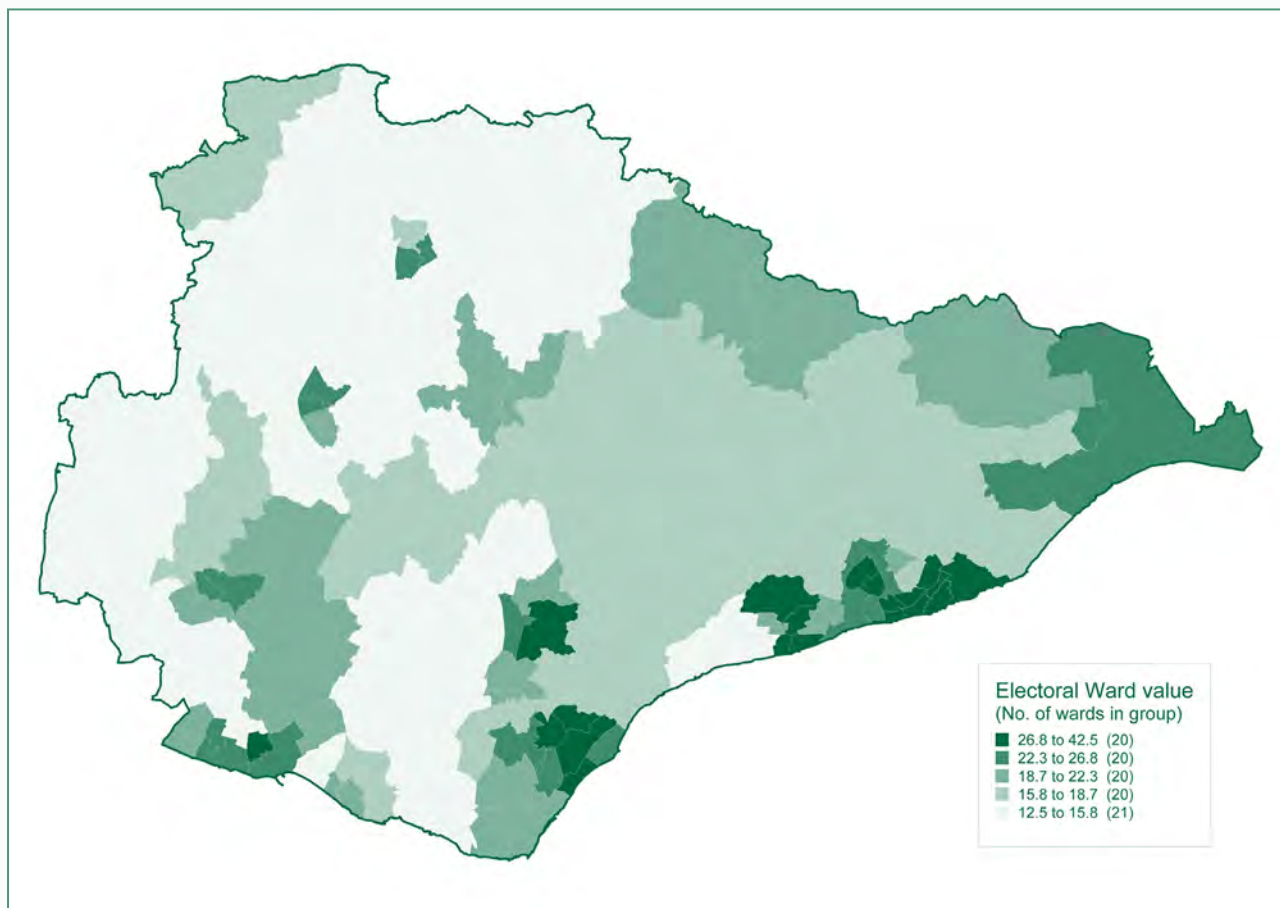
To provide guidance on approaches to addressing this multifaceted problem, the Department of Health published *A Smoke Free Future, A Comprehensive Tobacco Control Strategy for England* in February 2010. This new National Strategy sets out the former government's three objectives to deliver Tobacco Control in England. It is not clear yet whether this strategy will be adopted by the new administration; however, it builds on Tobacco Control policy direction over a number of years.

The three objectives are:

1. To stop the inflow of young people recruited as smokers
Aspiring to reduce the smoking rate among 11–15-year-olds to 1% or less, and the rate among 16–17-year-olds to 8% by 2020.
2. To motivate and assist every smoker to quit
Aspiring to reduce adult smoking rates to 10% or less and halve smoking rates for routine and manual workers, pregnant women and those in the most disadvantaged areas by 2020.
3. To protect families and communities from tobacco-related harm
Aspiring to increase to two-thirds the proportion of homes where parents smoke but that are entirely smoke-free indoors by 2020.

NICE has produced several sets of guidelines setting out recommended practice for Stop Smoking Service development and delivery. In addition, the Department of Health produces annual best practice guidance both for PCT commissioners and service providers. The recommendations from all these guidance documents inform the PCTs commissioning of stop smoking services.

Figure 51: Modelled estimates of current smoking amongst adults aged 16 or over, East Sussex electoral wards, 2003–2005



Source: East Sussex JSNA scorecards

Figure 52: Factors associated with stopping smoking



Source: A Smoking Free Future – A Comprehensive Tobacco Control Strategy for England. Department of Health 2010.

Tobacco control

Activity in East Sussex is focused in three key areas:

1. Stopping the inflow of young people recruited as smokers

The PCT and East Sussex County Council 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. New NICE guidance¹⁴ on smoking and young people was produced in early 2010 and this will inform future commissioning decisions in this area of work.

2. Motivating and assisting every smoker to quit

Smoking cessation services

The PCT commission evidenced-based stop smoking services to meet the needs of the local population. These are comprised of a specialist service provided by East Sussex Community Health Services (ESCHS), providing intensive interventions, including 1:1s and group support aimed at quitters with high levels of need or dependency. This includes additional services targeting the 20 wards across East Sussex with the lowest life expectancy (Investing in Life priority wards). In addition, the PCT commissions 1:1 smoking cessation services as a Locally Enhanced Service (LES) from General Practices and pharmacies across East Sussex.

In 2009/10, 3,342 people stopped smoking with East Sussex services.

Social marketing

Development of targeted promotional activity using social marketing approaches to encourage smokers to think about their smoking behaviour and to increase the numbers who want to quit, with advice and support from local services.

Brief interventions

ESCHS are commissioned to provide brief intervention training to key staff groups from a variety of organisations who come into contact with smokers. This training enables staff 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.

Targeted interventions

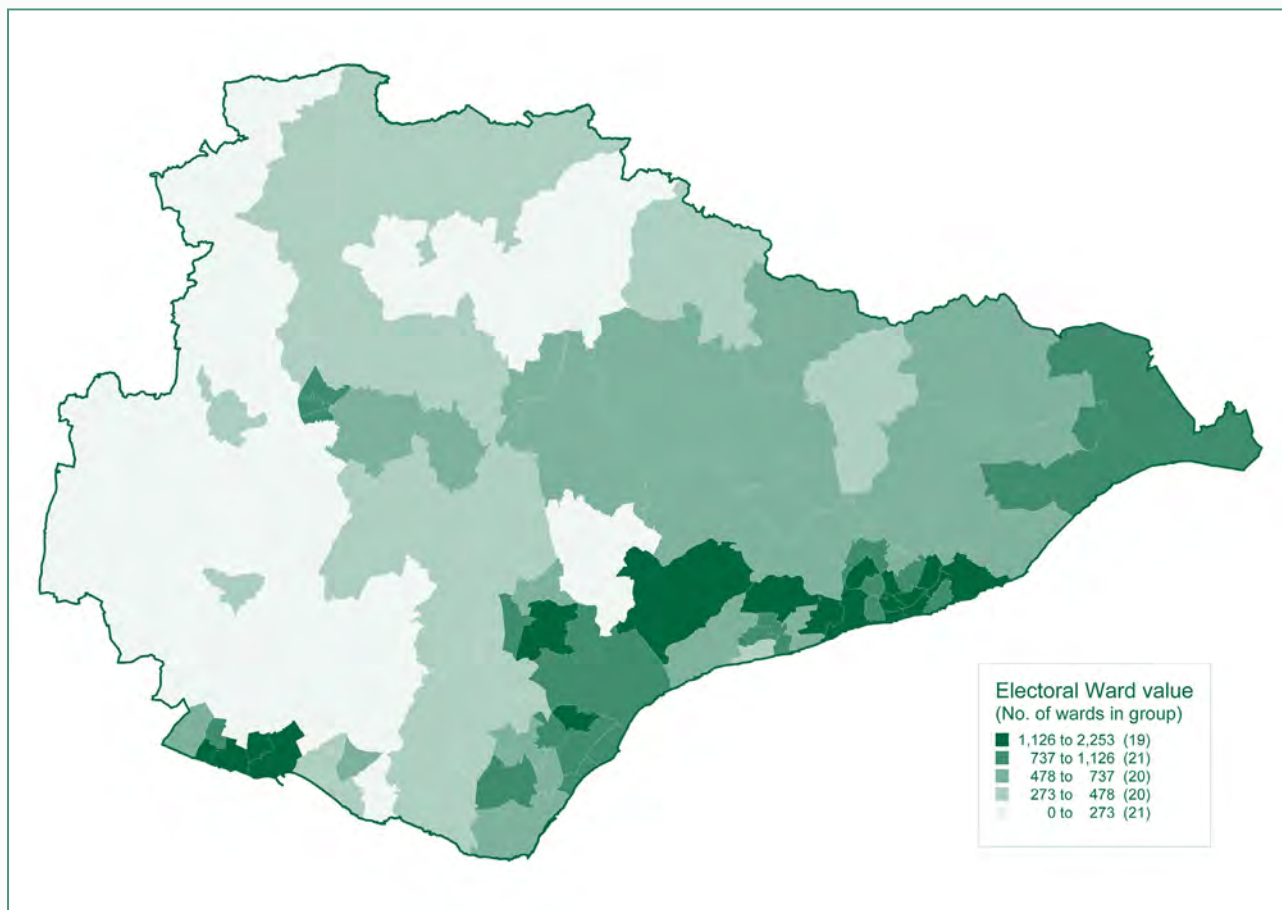
Building on a pilot 'Stop before your Op' campaign, the PCT has worked with its major provider of acute healthcare services, ESHT, to include in the Trust's quality related payment mechanism a payment for referring smokers to stop smoking services prior to elective procedures. This makes referring smokers part of the CQUIN payment framework and a proportion of ESHT income conditional on the achievement of quality improvement goals.

Specific interventions have been developed for priority groups such as targeting of pregnant women with referral by Midwives into the Specialist Service, and targeting of people in manual social groups through the on-going development of workplace-centred services in partnership with local employers.

Smoking cessation service data for 2009/10 indicates that services are attracting a higher proportion of quitters from areas of higher deprivation, in line with the expected need (Figure 53).

¹⁴ School based interventions to prevent smoking. National Institute for Health and Clinical Excellence, February 2010.

Figure 53: 4 week quitters per 100,000 population aged over 16 years, East Sussex electoral wards, 2009/10



Source: East Sussex JSNA scorecards

3. Protecting families and communities from tobacco related harm

The levels of compliance and public support for smoke-free legislation demonstrate that people are keen to reduce their exposure to second-hand smoke.¹¹ By 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 to be 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.

Targeted interventions for parents/carers of babies and pre-school children who smoke

Measuring progress

Measuring progress will be undertaken through performance against the following 2010/11 targets:

1. To achieve the PCT 'Vital Signs' 4 week quit target of 1,454 for Hastings and Rother and 1,987 for East Sussex Downs and Weald.
2. To achieve the East Sussex LAA 4 week quit target of 3,441.
3. To increase the percentage of quitters coming from the 20 wards with the lowest life expectancy, from 37% in 2006/07 to at least 50%.

National Support Team visit

In May 2010, the Department of Health's National Support Team (NST) for Tobacco Control visited East Sussex 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 five main recommendations on how partners in East Sussex could further enhance work in this area.

The top five take home messages from the visit were:

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 and 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 an integrated framework for stop smoking provision that is agreed by both commissioners and providers.

Obesity

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 BMI of an individual.¹⁵ 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. Table 18 shows the risk of developing obesity related co-morbidities. Evidence suggests that the major benefit of weight loss is that it improves not just one risk factor but the entire risk-factor profile, and even modest weight loss (5-10% of body weight) can have significant benefits.

Obesity prevalence

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. The 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.¹⁶

By 2015, the Foresight report (2007) estimates, using current projections, that 36% of men and 28% of women aged 21–60 years will be obese and, by 2050, 47% and 36% of men and women respectively will be obese.¹⁷ If this trend continues, millions of adults and children will inevitably face deteriorating health and a lower quality of life and, as a society, we would face spiralling health and social care costs.

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. Data on the incidence of obesity in different ethnic groups are limited because national surveys tend to sample only relatively small numbers from minority groups. For many ethnic groups, the sample size is therefore too small to allow for reliable comparisons or predictions.

¹⁵ *Healthy Weight, Healthy Lives: a cross-government strategy for England*. HM Government, 2008.

¹⁶ *Lightening The Load – Tackling Overweight and Obesity*. National Heart Forum, 2007.

¹⁷ *Foresight Project, Tackling Obesity: Future Choice's*. Government Office For Science, October 2007.

3 / How are we tackling Health Inequalities?

Table 18: *Classifications of underweight, overweight and obese*

BMI (kg / m ²)	Classification	Risk of obesity related co-morbidities
<18.5	Underweight	Low
18.5 to 24.9	Desirable weight	Average
25 to 29.9	Overweight	Increased
30 to 34.9	Obesity I	Moderate
35 to 39.9	Obesity II	Severe
> 40	Obesity III (Morbidly Obese)	Very severe

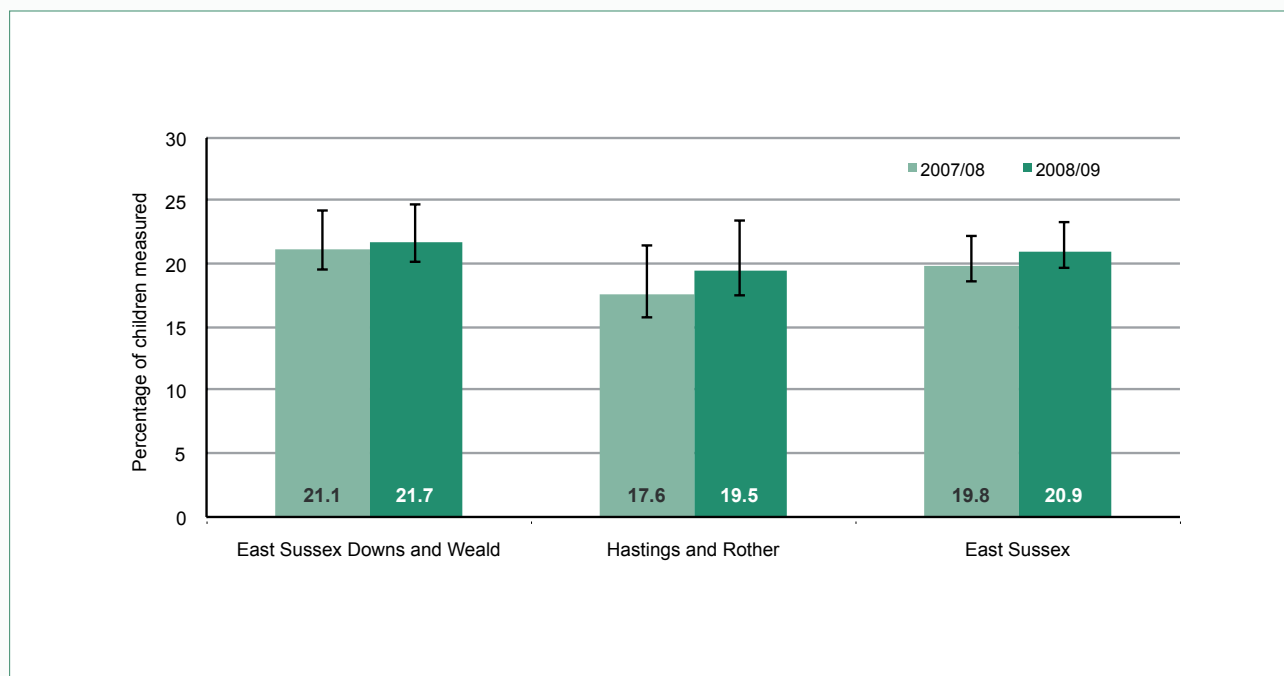
Obesity in children

The proportion of children in Reception Year at school who were obese or overweight increased in 2008/09 compared with 2007/08, and this increase was greater in Hastings and Rother (Figure 54). However, it is not clear using only two years of data if this rise indicates a trend or is due to random variation.

Figure 55 shows that children in Year 6 at school did not experience 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 that for the Reception Year (20.9%).

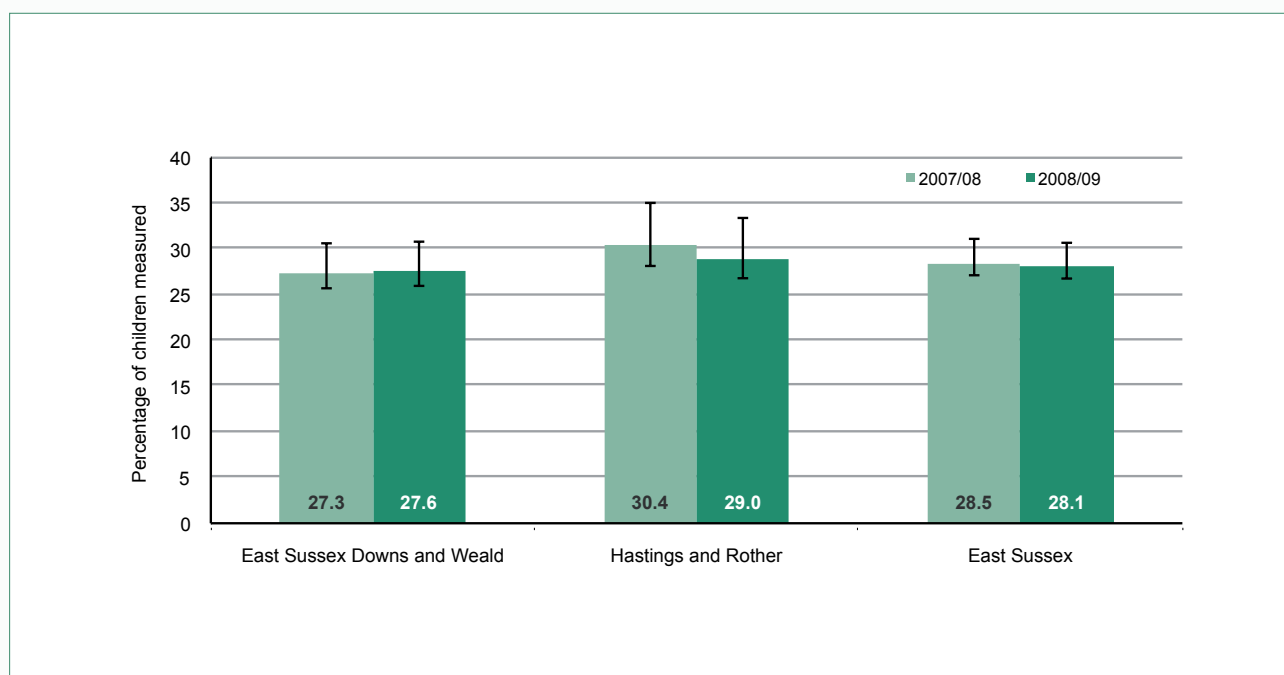
Figures 56 and 57 show that there are some slight differences in levels of childhood obesity according to deprivation. In Reception Year children, the highest rates of children who are overweight and obese are in the second most deprived quintile of East Sussex. In Year 6 children, it appears that there are higher rates of obesity compared to children who are overweight in the three most deprived quintiles of East Sussex. In the two least deprived quintiles, there are more overweight than obese children. Generally, the rates are higher in the more deprived quintiles.

Figure 54: *Percentage of children in Reception Year overweight or obese with 95% confidence intervals, East Sussex PCTs, 2007/08 and 2008/09*



Source: National Child Measurement Programme

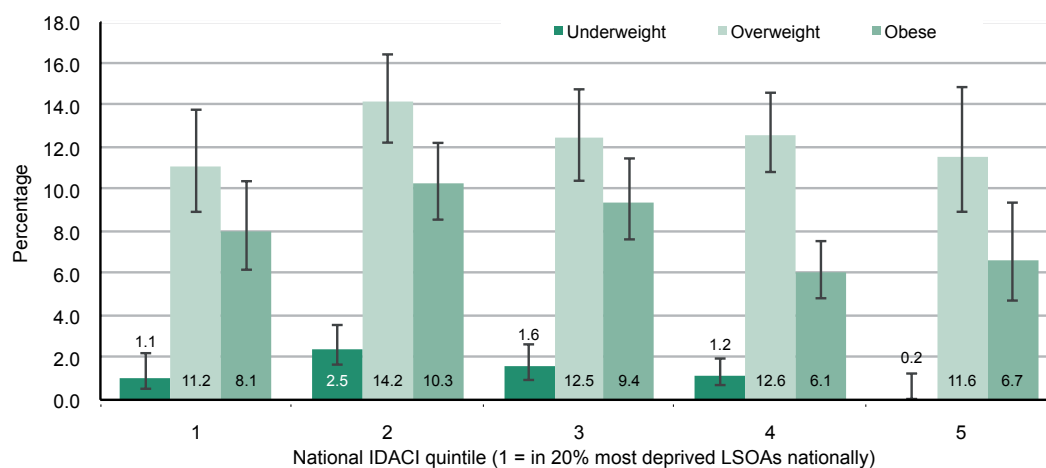
Figure 55: *Percentage of children in Year 6 overweight or obese with 95% confidence intervals, East Sussex PCTs, 2007/08 and 2008/09*



Source: National Child Measurement Programme

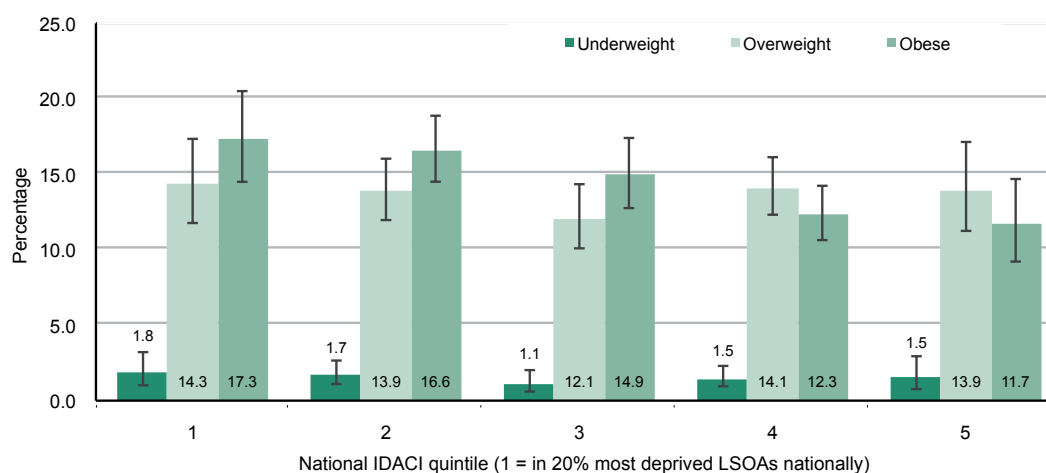
3 / How are we tackling Health Inequalities?

Figure 56: Prevalence of underweight, overweight and obesity by income deprivation affecting children, Reception Year, 2008/09



Source: National Child Measurement Programme and IMD 2007

Figure 57: Prevalence of underweight, overweight and obesity by income deprivation affecting children, Year 6, 2008/09



Source: National Child Measurement Programme and IMD 2007

Adult prevalence

Modelled data from the Health Survey for England indicates that obesity levels in Hastings are higher than elsewhere in East Sussex (Table 19).

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%.

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 (Figure 58).

Policy context and evidence base

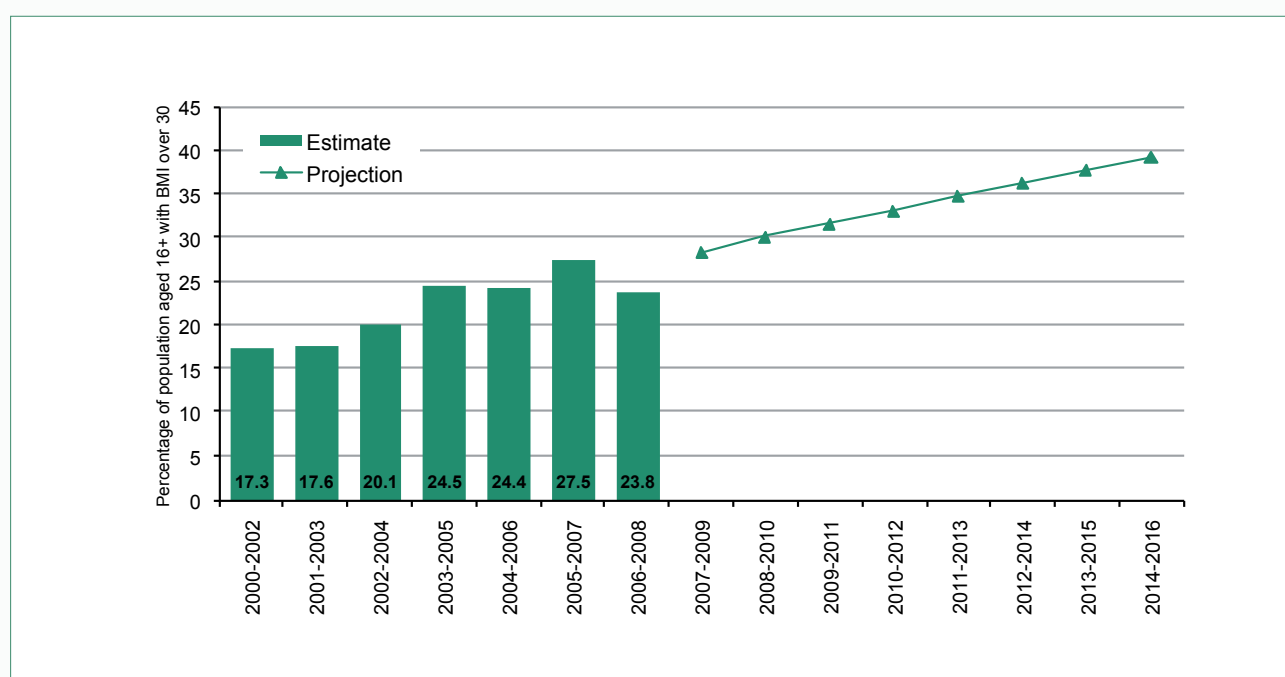
National policy to address obesity is set out in a number of key strategies, most recently *Choosing Health: Making Health Choices Easier* in 2004 and *Healthy Weight, Healthy Lives: a Cross Government Strategy* in 2008. NICE has produced guidelines setting out recommended practice for the provision of services relating to obesity, diet and physical activity.

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

Figure 58: *Obesity prevalence estimates for adults aged 16 years and over in East Sussex, 2000–2002 to 2006–2008*



Source: Health Survey for England estimates

Tackling obesity in East Sussex

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 further inform the PCTs work on obesity, a comprehensive needs assessment has been commissioned. To address inequalities in health, initiatives will be focused in particular on the 20 Investing in Life wards with the lowest life expectancy, where improving diet and increasing participation in physical activity can have a significant impact on addressing this key health outcome.

The PCTs and partners work together to focus and co-ordinate action to tackle obesity. 'Healthy Weight, Healthy Lives' 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. To support delivery of our aspirations to prevent people from becoming obese three specific health promotion roles have been commissioned from East Sussex Community Health Services: A Food in Schools Co-ordinator, a Food and Health Specialist and a Physical Activity and Health Specialist.

- 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

Background

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.¹⁸

Teenage pregnancy is associated with a number of negative health and social consequences, for both mother and child. These include problems associated with low birthweight, higher infant mortality rates, lower levels of breastfeeding 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.¹⁹

Improving sexual health has been identified as a priority area for action by the NHS and partner organisations. Targets and indicators include the following:²⁰

- A 50% reduction in the under-18 conception rate (births and abortions) by 2010 (from the 1998 baseline rate).
- Reduction in the prevalence of Chlamydia, with a target of screening 35% of 15–24-year-olds in 2010/11.
- Appointments offered within 48 hours to 100% of patients contacting GUM clinics.

The local picture

Teenage pregnancy

Teenage pregnancy is an important public health issue that is related to poor health and social outcomes for both mother and baby. For the mother, there is an increased risk of developing anaemia, pre-eclampsia (high blood pressure in pregnancy) and maternal and postnatal depression. There is an increased risk of infant mortality (60% higher rate), low birthweight, and some congenital abnormalities for the baby.

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. See Children's section for information on teenage pregnancy rates.

There is significant variation in under-18 conception rates within the county, with teenage conception rates in Hastings consistently higher and rates in Wealden consistently lower than the East Sussex average.

¹⁸ *Performing Better? A focus on sexual health services in England*. London: Commission for Healthcare Audit and Inspection, 2007.

¹⁹ Tripp and Viner. *Sexual health, contraception and teenage pregnancy*. British Medical Journal, 330: 590–93, 2005.

²⁰ *Moving forward: Progress and priorities – working together for high-quality sexual health*. London: COI. Department of Health, 2009.

3 / How are we tackling Health Inequalities?

The East Sussex Teenage Pregnancy Strategy 2010–2013

This strategy places a focus on tackling both the causes and consequences of teenage pregnancy, setting out proposals to improve the quality of integrated services, making them more flexible to meet the needs of young people. For example, it places emphasis on improving access to sexual health services, through providing services at times that fit with young people's lives. Work has already begun to achieve this through initiatives such as involving young people in the rebranding of young people's sexual health services, and implementing the nationally recognised "You're Welcome" quality criteria. This 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).

Chlamydia screening

Genital Chlamydia infection is the most commonly diagnosed bacterial 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 (PID), 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 diagnose and treat. Treatment and partner notification can reduce complications, which are estimated to cost the NHS millions of pounds per year.

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 (Table 20). However, fewer people tested positive for Chlamydia in East Sussex than on average for across 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.

Table 20: *Chlamydia screening rates 2009/10*

Area	% of 15–24-year-olds screened	% tested positive
NHS East Sussex Downs and Weald	24.1	4.3
NHS Hastings and Rother	24.0	4.2
NHS South Coast	17.1	5.6
England	22.1	6.0

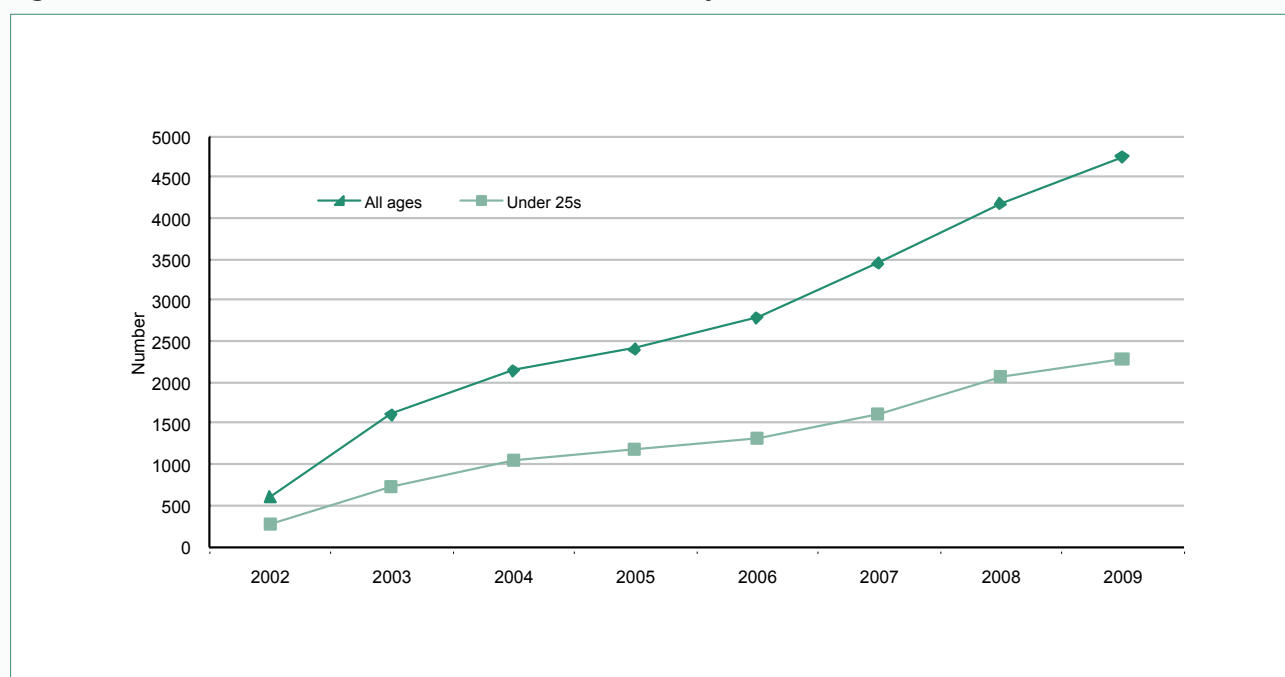
Other sexual health

Sexual health screening

The number of people screened for STIs 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 sexual health screens / HIV antibody tests carried out at East Sussex clinics. This too shows an increase in the number of people being screened but a less marked increase for younger people.

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



Source: East Sussex GU clinics

Mental Health and Wellbeing

Mental health promotion can be defined as simply 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. In the same way, someone can have poor mental wellbeing, but have no clinically identifiable mental illness.

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 years of age. 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 postnatal 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 population has a personality disorder.
- 1% of population have a serious mental health problem.

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, 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 with a mental disorder.

Contribution to wider health inequalities

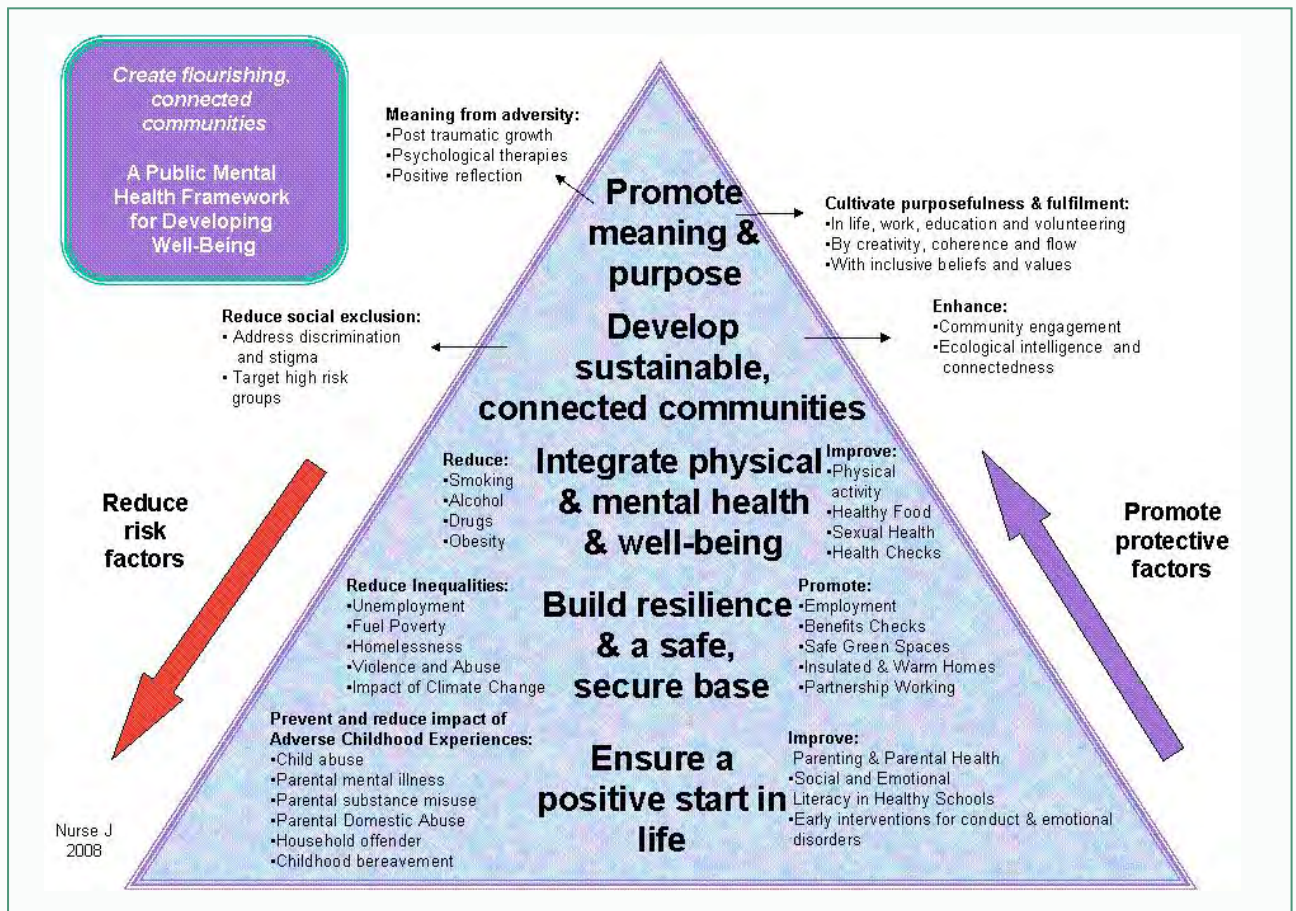
Mental health problems are linked to poor diet, less exercise, heavy smoking, drug and alcohol misuse. Depression at age 65 is linked to a 70% increased risk of dying early. People with diagnosed mental health problems are more likely to have risky lifestyles – e.g. smoking, drinking or drug use – and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

National policy

In 2004, the Department of Health published *Choosing Health, Making Healthy Choices Easier*. This identified the importance of improving health through mental health promotion. Set out below are the three levels of mental health promotion identified in the East Sussex PCTs Mental Health Promotion Strategies 2008–2011:

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)*: involves increasing social inclusion and participation, improving neighbourhoods and environments, developing areas of health and social services that support mental health, implementing anti-bullying strategies in schools and improving workplace health, community safety, childcare and self-help networks.
3. *Reducing structural barriers to mental health (structural)*: initiatives to reduce discrimination and inequalities and promote access to education, meaningful employment and housing and services and support for those who are vulnerable.

Figure 60: *New Horizons Framework – five areas to improve mental wellbeing*



Source: Flourishing People Connected Communities, A Framework for Wellbeing. Department of Health 2009.

New Horizons Framework

In 2009, the Department of Health published *New Horizons, A Shared Vision for Mental Health* and its accompanying framework *Flourishing People Connected Communities, A Framework for Wellbeing*. This guidance advocates a public mental wellbeing approach that focuses primarily on primary and secondary prevention. The framework proposes considering five areas to improve mental well being:

- **Prevention:** Focus on early prevention, in mainly primary (promoting population wellbeing) and secondary (targeting high risk groups).
- **A life-course perspective:** Three quarters of mental health problems start before adulthood.
- **Address inequalities:** Address inequalities in quality of service, access, health outcomes in severe mental illness, health outcomes with common mental health problems, impact of socioeconomic inequalities and discrimination upon mental health.
- **Integrate physical and mental health:** Our minds and bodies communicate and interact with each other, both affecting behaviour and health.
- **Ecological perspective:** We need to recognise and build connections within the individual, between individuals, communities and the environment.

Risk factors for poor mental health

Life 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.

What individuals can do to improve their own mental wellbeing

Five ways to mental wellbeing

The Foresight Project on Mental Capital and Wellbeing²¹ identified evidence-based interventions for individuals to promote their own mental wellbeing:

1. **Connect.** With the people around you, with family, friends, colleagues and neighbours. At home, work, school or in your local community. Think of these as the cornerstones of your life and invest time in developing them. Building these connections will support and enrich you every day.
2. **Be active.** Go for a walk or run, step outside, cycle, play a game, garden, dance. Exercising makes you feel good. Most importantly, discover a physical activity you enjoy and that suits your level of mobility and fitness.
3. **Take notice.** Be curious, catch sight of the beautiful, remark on the unusual, notice the changing seasons. Savour the moment, whether you are walking to work, eating lunch or talking to friends. Be aware of the world around you and what you are feeling. Reflecting on your experiences will help you appreciate what matters to you.

4. **Keep learning.** Try something new, rediscover an old interest, sign up for that course, take on a different responsibility at work, fix a bike, learn to play an instrument or how to cook your favourite food, set a challenge you enjoy achieving. Learning new things will make you more confident as well as being fun.
5. **Give.** Do something nice for a friend, or a stranger, thank someone, smile, volunteer your time, join a community group, look out as well as in. Seeing yourself and your happiness as linked to the wider community can be incredibly rewarding and creates connections with the people around you.

Local action to promote mental wellbeing

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

Key interventions that have been implemented include:

²¹ Foresight Mental Capital and Wellbeing Project. Final Project report – Executive summary. The Government Office for Science, London, 2008.

Mental Health Awareness Campaign

A series of innovative media to promote the importance of good wellbeing, provide tips for self care and contact details of local and national support organisations.

A booklet was produced in collaboration with partners: Taking care of your top two inches: a guide to wellbeing. This has been distributed widely across the county, and positive anecdotal feedback on its usefulness has been received from a number of partners. An adapted version was produced in collaboration with HMP Lewes for use within the prison and other offender management settings.

An innovative Mind your Head: how well do you score? scratch card was also produced that encouraged people to assess their own mental health and provided 12 recognised self help steps that people have found useful when trying to achieve positive mental wellbeing. Users are then referred to the local website www.mytoptwoinches.com for further information. The production of a version specifically designed for black and ethnic minority communities is also planned.

Other media based initiatives delivered included:

- a local radio campaign to coincide with World Mental Health Day;
- re-launch of the FMH website fmhsussex.co.uk that has been designed especially for young men aged 16–25 years with information and advice and sources of support; and
- roving art and photography exhibitions promoting work largely developed by mental health services users and individuals who have experienced mental ill-health.

The development and distribution of resource packs to a range of organisations that included GP practices and workplaces were also undertaken.

A ‘Books can help’ scheme was also developed in collaboration with East Sussex County Council Library Services and Sussex Partnership NHS Foundation Trust. This promoted reading, the availability of self help books and other resources from local libraries.

The NHS, with other partners, supported the production of an updated edition of Good Health Guide published by Activ8 (Hastings and Rother Mind). This new edition provided greater emphasis on East Sussex wide services.

Networking events promoting mental health awareness were also held in collaboration with partners; e.g. Rethink.

Supporting organisations to deliver community based interventions that support those with mental health problems

Small grants have been awarded to a number of local organisations to support them to develop community based responses to mental wellbeing via a series of small health improvement grants, several of which have included support to deliver training for front line staff on mental wellbeing and suicide prevention.

Next steps for promoting healthy lifestyles

1. Review commissioning for health improvement to ensure that interventions are evidence based, cost effective and address the needs of the most vulnerable first.
2. Review health improvement strategy and action plans to ensure that these incorporate the findings of this report, recent needs assessment and new policy guidance.
3. Improve access to health improvement services by providing information on how to access services such as smoking cessation, Health Trainers, local leisure services, walking schemes, etc. to all those who have contact with key groups and individuals. Simplify arrangements for accessing services – e.g. through a single point of referral – so that it is easy to refer people into them.
4. Identify the health promotion training and support needs of frontline workers and commission training to address these.
5. Commission specialised health improvement services, support and workforce in line with the competencies set out in the Public Health Skills and Career Framework.

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

Introduction

As described in Chapter 2, circulatory diseases, cancer and respiratory diseases contribute significantly to the gap in life expectancy between the well-off and the less well-off. Here we describe work to address these diseases. Our focus is on work within primary care services, with some discussion on secondary care (hospital services).

Secondary prevention work, which is normally undertaken within primary health care services, is important in reducing health inequalities. Secondary prevention, which addresses the symptoms of ill health in order to control further problems, should run alongside activities that address the 'upstream' causes of health inequalities (such as the income and education gap). Primary prevention activity, such as encouraging an increase in physical activity and identifying and treating high cholesterol, can also 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

Cardiology is one area that has been prioritised by GPs through the practice-based commissioning programme. Schemes in East Sussex aim to support the provision of care closer to home. An example of one scheme is non-emergency adult cardiology referrals to secondary care from Hailsham. 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, a consultant-led, community-based cardiac clinic, to be run from Newhaven Downs Polyclinic, is in development.

In the Hastings and Rother area, a scheme called Hastings and Rother Treatment for Hearts (HARTH) is in place. The purpose of the service is to promote secondary prevention by ensuring that patients with CHD are cared for in a systematic way using an agreed template and following agreed protocols. The overall aim is to help patients lead a healthy lifestyle and optimise their medical treatment, thus improving their functioning and prognosis.

Atrial fibrillation (AF) is a cardiac arrhythmia which is a significant risk factor for developing a stroke. In identifying and treating AF in primary care, it is essential that practices follow new national guidance. Over the past year, the Sussex Heart Network (SHN) have been supporting and auditing practices 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 CHD generally and the work to support targeted prevention of harmful drinking, described earlier in this chapter, is essential in tackling the life expectancy gap.

Warfarin is prescribed for those in AF, in order to reduce the stroke risk. Anti-coagulation 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 practice-based commissioning schemes are in place in the NHS Hastings and Rother, and NHS East Sussex Downs and Weald, areas.

3 / How are we tackling Health Inequalities?

Over the last two years a practice-based commissioning scheme has been developed across the whole of NHS East Sussex Downs and Weald. This has been introduced in stages and now provides a community-based service for initiation and maintenance of anti-coagulation therapy across almost the entire PCT. The last few practices still to offer this service are in the final stages of setting up protocols and systems to introduce the service by August 2010.

The new service for anti-coagulation monitoring is designed to:

- establish a common standard across the PCT
- improve anticoagulation control
- improve patient safety
- reduce potential for errors in dosing
- ensure the need for continuation of therapy is reviewed regularly
- ensure that the therapy is discontinued when appropriate
- ensure that all participating practices are using computer decision support software to calculate dosing
- improve patient convenience and satisfaction

The clinics are held in general medical practices 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.

The SHN will be working to encourage more appropriate initiation of warfarin prescribing in the coming year.

People with a diagnosis of psychosis are also at increased risk of physical health problems such as CHD. A 'Quality and Outcomes' indicator is aimed at increasing the percentage of people with these mental health problems who are recorded as having a review in the preceding 15 months. In the review, there should be evidence that the patient has been offered routine health promotion and prevention advice appropriate to their age, gender and health status. Currently, primary care services in East Sussex are, over all, not undertaking these reviews to the levels that most other PCT areas are achieving, although uptake is 92%. The percentage increase needed to bring the level into line with other areas is very small.

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. Because the service needs to run 24 hours a day, 7 days a week, and is provided by highly specialised staff, it is recommended that centres of excellence are developed. However, it is important to take into account the needs of populations from more deprived areas when undertaking service changes of this nature and a service change that has a differential impact on more deprived communities is not acceptable. Therefore, the benefits of more specialised services need to be balanced with the travel times of different populations. For this reason, it has been decided to undertake primary angioplasty in East Sussex, the details of the service configuration will be agreed in 2010.

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

Variations in controlling hypertension and high cholesterol across population groups contribute to the life-expectancy gap described in Chapter 2. Similarly, type II diabetes increases the risk of CHD, and controlling blood sugar in those with diabetes to the same extent across all income groups will help reduce inequalities in health.

The NHS health checks programme was described in last year's public health report. It aims to offer all 40–74-year-olds an assessment of their vascular risk, followed by appropriate risk management. A local agreement is in place for practices to keep a record of those people at high risk of cardiovascular disease. In 2009, over 130 staff, including practice nurses, pharmacists, health trainers and health care assistants, attended a half-day course on assessing and advising on CVD risk.

Health checks commenced 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 (i.e. practices covering the wards prioritised in the Investing in Life Programme – see Chapter 2).

In the NHS East Sussex Downs and Weald area, the following checks were undertaken in 2009/10: in Investing in Life (iL) practices, 12 practices have shown activity and have completed 1,222 checks, 37% showing a high risk. 'High risk' means a 20% or greater risk of developing CVD over the next ten years. In other NHS East Sussex Downs and Weald practices, 15 practices have performed 1,741 checks and 30% of these were at 20% or greater CVD risk.

In the NHS Hastings and Rother area, 15 iL practices have carried out 1,514 assessments, 41% showing a high CVD risk. In other NHS Hastings and Rother practices, 11 practices have performed 1,259 assessments; 23% showing a high CVD risk.

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. There is variation in this prescribing across the county and the medicines management team, in conjunction with GPs, are planning to address this issue in 2010/11. However, there is also a need for primary prevention, as described earlier in this chapter.

Those living with long-term conditions, such as CHD 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.

3 / How are we tackling Health Inequalities?

Cancer

Nationally

Cancer is the leading cause of death for both men and women in England. The three most common cancers are: lung, prostate and colorectal for men, and breast, colorectal and lung for women. Cancers, such as those strongly related to smoking and alcohol (i.e. larynx, lip, mouth, pharynx and lung), have a higher incidence and higher mortality rates in more deprived areas. Cervical cancer also shows higher incidence in more deprived areas. Testicular cancer, malignant melanoma, non-Hodgkin lymphoma and cancer of the uterus often have a higher incidence in more affluent areas of the UK.

It is estimated that, in total, 25,600 cases of cancer and 17,500 deaths could be prevented each year in the UK and Ireland if the incidence and mortality rates were reduced everywhere to those found in the areas with the lowest rates. Most of this prevention could be achieved by reducing alcohol and tobacco use.²²

England has lower survival rates in the first year after diagnosis for many cancers compared to other EU countries. Low one-year survival rates are partly due to late stage at diagnosis, because of delays at patient, primary or secondary care level.

To improve one-year cancer survival rates in England, the Department of Health and Cancer Research UK have funded projects across the country to raise awareness of the early symptoms of cancers. The aim is to encourage patients to seek health advice early on, as well as looking at reducing delays in primary care in order to increase early diagnosis.

National data show that men have a 60% higher mortality rate for non-sex-specific cancers compared to women and, that people from more deprived areas, and men in general, are less aware of early cancer symptoms.

Locally

Sussex has a high incidence of cancer due to its elderly population. East Sussex 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.²³

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.²⁴

To improve cancer survival rates in the first year after diagnosis, and 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. The national initiative is aimed at improving public awareness of early cancer symptoms. It aims to encourage people to seek advice earlier and reduce delays in primary care. East Sussex has received funding to deliver a cancer awareness campaign, together with outreach cancer awareness sessions for the public and health professionals. Within the funding available, the campaigns are focusing on raising awareness of early symptoms of bowel, prostate and lung cancer. The campaigns are targeting men aged over 45 years in Hastings and Eastbourne, in the first instance.

The campaign messages have been informed by focus groups carried out with men aged over 45 years across East Sussex. Campaigns are delivered by a social marketing company in partnership with 'Albion in the Community' football staff, with advice from the PCT.

²² *Cancer Atlas of the UK and Ireland*. Cancer Research UK, 2005.

²³ Thames Cancer Registry data 2007, provided by Sussex Cancer Network, 2010.

²⁴ Thames Cancer Registry data 03/06, combined with PCT health intelligence data 2009.

Partnership working to help get the message across has also been undertaken with pharmacists, Lewes prison staff, GP practices, Hastings council, voluntary organisations, local media, leisure centres, betting shops, pubs and others.

As part of the campaign, 11 cancer awareness sessions have been delivered in workplaces and community venues to key community members including: football coaches, health trainers, prison staff and taxi drivers. Furthermore, seven pub cancer-awareness sessions have also been delivered in Hastings and Eastbourne by 'Albion in the Community' footballers. Training sessions have also been delivered to pharmacists, health trainers and homeless centre staff. The sessions have reached more than 450 people, including health care professionals, 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.

To support the campaign, information has been publicised through local media across East Sussex, including local radio stations. Leaflets and posters have been distributed to a wide range of settings; for example, car boot sales and football matches. Beer mats and mugs with key campaign messages have also been delivered to pubs and cafés, and posters have been put up in public toilets. Local workplaces have been informed about the key campaign messages via e-mail shots.

To help get the messages across to men, we have also piloted sending out letters and flyers to all men age over 45 years registered with three surgeries in St Leonard's and Hastings.

The campaign will be evaluated later this year to inform future work to improve 1-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.

Respiratory diseases

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, incidence of COPD is higher in these populations. Cold and damp environments, poor diet and other problems associated with low incomes and poverty aid disease progression.

A local enhanced primary care service is provided to patients over 40 who are smokers. These patients are screened in primary care via the provision of spirometry 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 readmission rate for people with a diagnosis of COPD.

3 / How are we tackling Health Inequalities?

The PCTs' pharmacy team have been working with a lead respiratory consultant at ESHT on updating local guidelines for the medicines management of COPD, based on NICE guidance. Following consultation on the new guidelines, educational meetings focused on implementation will take place in 2010/11. It is anticipated that ensuring that as many patients as possible are treated optimally with medicines will significantly reduce COPD exacerbations and therefore morbidity associated with this disease.

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 practices in prescribing for pneumonia, and work with care homes and A&E departments has 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.

Protected learning time

It is essential that practice staff stay up-to-date with clinical and management skills and knowledge. A series of learning events were held for primary care staff in both the western and eastern sides of East Sussex in 2009/10. In NHS Hastings and Rother in September 2009, a whole afternoon was devoted to CHD, with sessions on new CHD treatments, echocardiograms and interpretation of ventricular functions. Cancer update sessions have been delivered to both East Sussex areas. COPD was also discussed in the NHS East Sussex Downs and Weald area in a session covering QoF. Practice nurses have also had recent updates on respiratory illness.

The future

Local NHS services will be focusing on transforming relationships between the hospitals and primary care so that services can be more integrated and patients do not have to go to hospital for treatments that can be less costly if provided by a community nurse, general practitioner or other service. The patient pathways for circulatory diseases, respiratory problems and mental health services are included in this transformation programme and will be reviewed in detail over the coming year.

Recommendations

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 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

Introduction

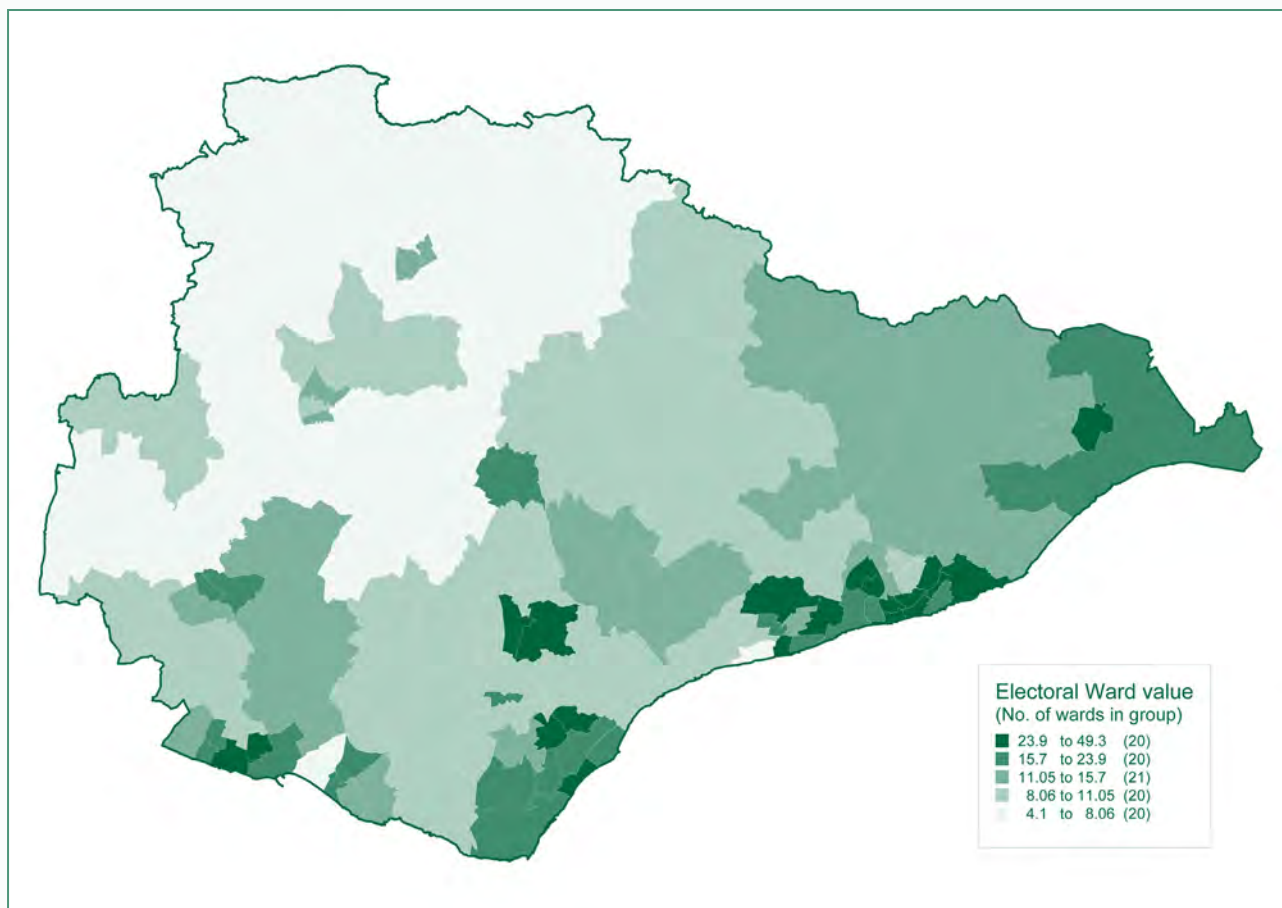
We know a good deal about the health and wellbeing of children and young people in East Sussex, based both on statistical data and on the results of surveys/consultation of both young people themselves and their families. There is wide variation across East Sussex in the proportions of children who experience income deprivation (Figure 61).

The key agencies whose work affects the lives of children and young people are all members of the East Sussex 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. The current plan identifies as its key challenge that of narrowing gaps in outcomes,

recognising that, while many children and young people enjoy a very good quality of life and have excellent prospects in relation to both their own happiness and their contribution to their communities, there is a significant minority for whom outcomes are much worse than the rest. The plan sets out a commitment to address this outcomes gap through a combination of:

- a holistic, integrated approach to supporting all children, young people and families, including through effective early intervention when problems arise; and
- a range of focused strategies to improve particular outcomes; for example, improving educational attainment and reducing teenage conceptions.

Figure 61: *Income Deprivation Affecting Children Index 2007, electoral wards in East Sussex*



Source: Index of Multiple Deprivation 2007

3 / How are we tackling Health Inequalities?

The CYPT partnership has now begun work on the development of a new plan for 2011–2014 against the challenging background of a significant reduction in public sector funding. The aim is to identify a small number of key priority outcomes, for which there are known to be significant inequalities to be addressed, and to develop targeted joint programmes that make the best use of the funding available across the partnership.

There are numerous services and work areas with the core aim of reducing inequalities in children. These include Children's Centres, the Family Nurse Partnership, reducing teenage pregnancy, increasing breastfeeding, securing good emotional and mental wellbeing and improving communication skills and emotional and social development.

The Healthy Child Programme 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.

Healthy Child Programme

The Healthy Child Programme is the universal prevention and early intervention programme for all children and families, which enables them to achieve their optimum health and wellbeing.

It is divided into a programme for 0–5-year-olds, available to all parents with children from pre-birth until the child enters school, which covers:

- The assessment of the child and family's needs
- Health promotion
- Childhood screening
- Immunisations
- Early interventions to address identified needs
- Safeguarding children from harm

There is also a programme for 5–19-year-olds, which includes:

- Health assessment at school entry in reception / Year 1 (4/5 years) and at school transition / Year 7 (11/12 years)
- Emotional health, psychological wellbeing and mental health
- Promoting healthy weight
- Support for parents and carers
- Immunisations
- Young people entering further education
- Sexual health
- Physical activity

The Healthy Child Programme contributes to reducing inequalities by varying the level of support and input according to the needs of children and families. This is termed a progressive universal service, which means that it is a universal service offered to all, with additional preventative services for those with specific needs and risks that may have an impact on future health and wellbeing.

It works within the Every Child Matters Framework and the National Service Framework for Children, Young People and Families, and is delivered in partnership across Health and County Council Children's Services.

The areas included for high-risk children and young people and their families are:

- Immunisation of at-risk children and young people (e.g. vaccination for those at high risk of tuberculosis)
- Additional emotional health, psychological wellbeing and mental health needs
- Overweight and obese children
- Drug and alcohol misuse
- Smoking cessation
- Specific groups of at-risk young people, including those who are looked after and those with behavioural issues.

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 Early Years Commissioning Team are responsible for the development and management of Children's Centres across the county.

Children's Centres have evolved from Sure Start Centres, which were initially established in the most deprived communities and provide a range of services and support for families and young children. The core aim is to reduce health inequalities and improve health outcomes for children aged 0–5 years. This is through supporting health partners deliver the Healthy Child Programme (2009).

Sure Start brings together childcare, early education, health and family-support services for families with children aged under 5 years. Working with parents-to-be, parents, carers and children, it promotes the physical, intellectual and social development of babies and young children so that they can flourish at home and when they get to school. Sure Start brings together service providers from the statutory sector, such as health, social services and early education, as well as voluntary, private and community organisations and parents themselves, to provide integrated services for young children and their families based on the needs of local children and parents.

Children's Centres are open to all families and children in the local area and allow networking, provide free child-care and offer subsidised refreshments. They also provide many services at an enhanced level, for those families and children identified as requiring additional support via the Healthy Child Programme. For example, this includes the additional support midwives, who provide holistic additional antenatal support alongside the core midwifery service to families identified as vulnerable.

Another key area of work is the provision of parenting support, to improve attachment and attuned parenting, particularly during the first few months and years of life, for those more vulnerable families.

The following services are provided in most Children's Centres:

- Baby massage groups
- Baby signing sessions
- Breastfeeding support groups (with National Child Birth Trust)
- 'Chatter Matters' group to support early attachment and improve language skills
- Parenting support on a one-to-one basis and in groups
- One-to-one home visiting support for issues that could affect a child, for example:
 - Depression.
 - Dealing with practical issues such as housing
 - Signposting to partner agencies such as CRI Families and Parenting Service
- Attendance by CRI, JobCentre Plus, housing and counselling support services

In addition, Children Centre venues are provided to support the co-location of health and midwifery staff to enhance multiagency working, and to provide client-friendly settings for Child Health Clinics, other groups such as antenatal and postnatal groups, and Speech and Language Therapy 'Drop in' sessions. The emphasis is on providing a service driven by client need, with increased inter-agency working and improved communication between services supporting those most in need. This has been supported by:

- A data sharing agreement, where a child can be registered at a Children's Centre following birth.
- The use of the Common Assessment Framework as the referral route between health visiting teams and the Family Outreach Support service.

Family Nurse Partnership

The Family Nurse Partnership Programme (FNP) is an evidence-based programme that has been in place in America for the past 30 years. It 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 2 years of life. It is offered to women and their partners, identified as requiring extra support, with a first pregnancy and generally to those up to the age of 20 years. It is a structured programme delivered by specially trained family nurses who have largely been drawn from health visiting and midwifery or mental health and school nursing.

The evidence base from America demonstrates significant and consistent short- and long-term benefits for children and families. Key outcomes from randomised controlled trials include the following:

- Improvements in women's antenatal health
- Reductions in children's injuries
- Fewer subsequent pregnancies
- Greater intervals between births
- Increases in fathers' involvement
- Increases in employment and earnings
- Reductions in welfare dependency
- Improvements in school readiness
- Reduced arrests and criminal behaviour for children (at 15) and mothers

The FNP team was established in Hastings and St Leonards (Wave 2 of the national programme) in September 2008.

There are 90 young parents on the caseload, with a further eight waiting to be recruited. There have been 80 babies born to date. The team work with a number of black and minority ethnic clients, using interpreters as appropriate, and all young parents on the programme are introduced to and encouraged to use Children's Centre services.

FNP is a specialist programme benefiting those mothers with low psychological resources.

It is at the 'intensive care' end of progressive universal preventive and early intervention services, with close working relationships with other services and programmes. In the future, it should 'fit' within the progressive, intensive end of the Healthy Child Programme.

The FNP appears to be successful in helping parents to make changes in their behaviour and make the emotional developments that are needed in order to care well for their infant.

The FNP supports delivery of government priorities including:

- Breastfeeding
- Reducing smoking in pregnancy
- Obesity prevention
- Reducing inequalities
- Reducing subsequent teenage pregnancies
- Prevention of youth crime
- Improving school readiness
- Supporting sensitive and effective parenting
- Supporting relationships

It also supports the 'think family' policy.

Investment in children's early years forms an essential building block for their achievements in later life and the potential return is larger than for other investments in human capital due to the length of time over which those returns can be realised.²⁵

²⁵ Heckman, James J. *Skills Formation and the Economics of Investing in Disadvantaged Children*. Science, 312(5782): 1900–1902, 2006.

Teenage pregnancy

Background

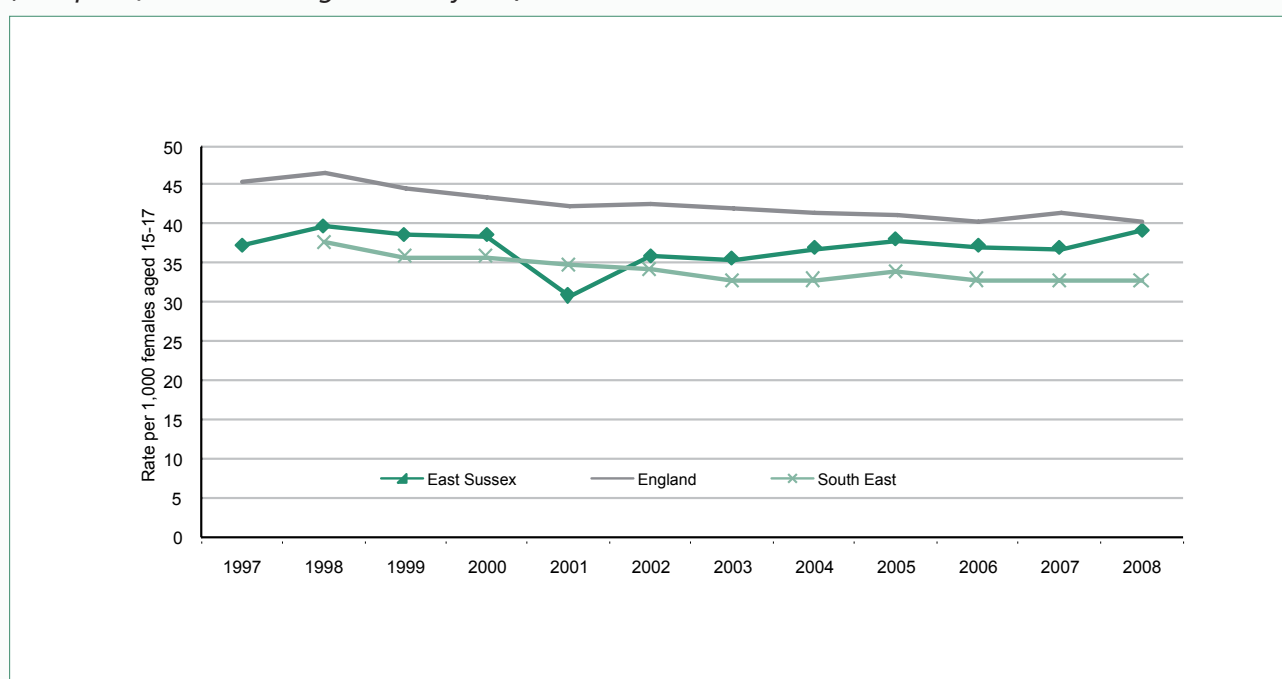
The factors leading to teenage pregnancy are complex and partnerships across key areas such as education, youth services, sexual health services, housing and local voluntary and community groups is essential in order to reduce rates.

Local picture

There is a national target to halve the under-18 conception rate by 2010, using 1998 data as the baseline. In 1998, the East Sussex rate was 39.2 per 1000 population. There is a time-delay of 14 months in obtaining verified data on teenage pregnancy. This is to allow for births to be registered and data on terminations of pregnancy to be collated.

The latest data available is for 2008. The overall East Sussex reduction for 2008 was a 1.5% reduction from the baseline, with the county rate at 39.2 per 1000 females aged 15–17 years old. At district and borough level, there is more variation in conception rates from year to year due to the relatively small number of teenagers who become pregnant. At ward level, there is an association between the wards in East Sussex with the lowest life expectancy and those with the highest rate of teenage pregnancy. The wards in Hastings with the highest rates of teenage pregnancy are Central St Leonards, Hastings Tressell and Castle ward; these wards also experience relatively high levels of social deprivation. Teenage pregnancy data relates to the number of conceptions in a given area. Another important indicator is the termination rate within an area. In East Sussex Hastings has the lowest percentage of terminations and the highest number of live births.

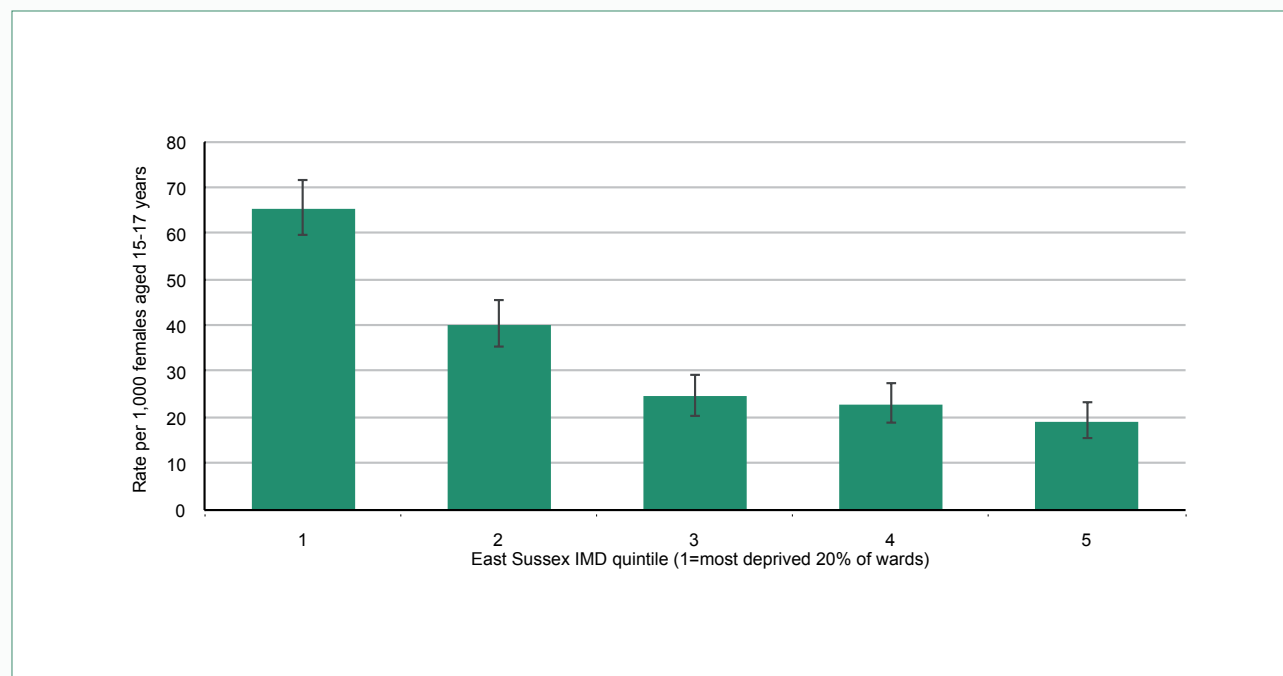
Figure 62: Under 18 conception rate for East Sussex, 1997–2008
(rate per 1,000 females aged 15–17 years)



Source: ONS

3 / How are we tackling Health Inequalities?

Figure 63: Under 18 conception rate with 95% confidence intervals by deprivation quintile, East Sussex, 2005–2007



Source: ONS and IMD 2007

The above figure clearly illustrates the link between deprivation and rates of teenage pregnancy. Teenagers living in the most deprived areas of the county have a rate of teenage conceptions of 66 per 1000 population, compared to 19 per 1000 population in the least deprived parts of East Sussex.

Action to reduce rates

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, all of which are the key pillars of reducing rates of teenage pregnancy. It is also important that efforts to reduce teenage pregnancy are joined up with other services, including the Chlamydia Screening programme, the HPV vaccination programme, wider sexual health service provision (including termination of pregnancy services) and the implementation of the maternity strategy.

The multi-agency Teenage Pregnancy and Sexual Health Partnership Board has prioritised six strategic areas for 2010/11, based on the national strategy ‘Teenage Pregnancy Strategy, Beyond 2010’:

- Prevention and wellbeing
- Commissioning and service re-design
- Workforce
- Leadership
- Communication
- Support for teenage parents

These areas will form a detailed action plan for the East Sussex Teenage Pregnancy and Sexual Health Action Group.

The key points include:

Prevention and wellbeing

- Improve young people’s access to and use of effective contraception when needed
 - Increase availability and uptake of Long Acting Reversible Contraception, through Primary Care, Sexual Health and Termination services.
 - Improve access to Sexual Health services, including times and places that fit in with young people’s daily lives.
 - More joined-up working with other risk-taking areas, including alcohol and substance misuse.
- Give young people the knowledge and skills they need to experience positive relationships and good sexual health
 - Consistent delivery of Sex and Relationship Education in schools.
 - Further provision of ‘Speakeasy’ course for parents to discuss sexual health with children.
 - Teenage Pregnancy Prevention Project in schools.
- Intervene early with those most at risk
 - Targeted Sex and Relationship Education and sexual health advice for at risk groups of young people including children and young people in care, those leaving care, those in supported housing and those who are not in education, employment or training.

Commissioning and service re-design

- Joint commissioning with substance misuse services and child and adolescent mental health services.
- Implement ‘Your Welcome’ standards across all sexual health services (these ensure compliance with minimum standards for being ‘young people friendly’).

Workforce

- Further develop the skills and confidence of the wider children’s workforce, including schools and school governors.
- Wider children’s workforce trained to identify risk and know where to signpost for more specialist support.

Leadership

- Senior management representation at Teenage Pregnancy Partnership Board, both at PCT and County Council.
- Reducing the teenage pregnancy rate is a local priority within the Local Area Agreement.

Communication

- Regular campaigns led by young people and accessible to all within universal and targeted services.
- Effective and meaningful participation of young people in East Sussex re-branding of sexual health services.

Support for teenage parents

- Common Assessment Framework in place for all young parents.
- Expansion of Family Nurse Partnership across East Sussex.
- Improved support for young fathers.

3 / How are we tackling Health Inequalities?

Through additional funding for increasing access to contraception, there are a further two priority areas for implementation:

1. **Increasing access to long acting reversible contraception**

Funding is available in 2010/11 to support primary care to access training in STIs and in the provision of long acting reversible contraception. This will be matched with information for young people both encouraging uptake and listing where they can obtain these services.

2. **Enhanced sexual health services within Community Pharmacy**

Community Pharmacists are being offered training to provide free emergency hormonal contraception, free pregnancy testing, Chlamydia testing and C Card (to obtain condoms). They will also be trained in how to engage with young people. This will be matched with a new electronic data collection system to monitor take up of the new services.

There are also local action plans led by the Healthy Schools Service that target the schools with the highest rates. Specific actions include: group work for those aged 11–14 years, covering self-esteem, friends, aspirations and use of alcohol; targeted work with school leavers aged 15 and over who are not in education, employment or training; and development of schools-based sexual health services.

Breastfeeding

Breastfeeding is universally accepted as the optimum form of nutrition for infants to give them the best start in life. It is nutritionally and immunologically superior to any other form of infant feeding and is recommended for all babies and mothers, and increases children's future life chances.²⁶

Breastfeeding is a global and a national priority and a key focus for the NHS and local partners in tackling health inequalities. It saves lives and protects the health of mothers and babies in both the short and long term. Breastfeeding services are a cost-effective intervention, contributing to savings from reduced hospital admissions for gastro-intestinal and respiratory infections in infants.²⁷

Breastfed babies are also less likely to become obese and less likely to develop some allergies. The World Health Organisation recommends that all babies should be exclusively breastfed for a minimum of six months and that breastfeeding continues thereafter alongside suitable weaning foods.

Evidence suggests that many of the health benefits of breastfeeding or receiving breast milk become more pronounced with longer feeding, and that early weaning may detract from the baby receiving the optimum effect of breast milk. Therefore, the recommendation is that infants are exclusively breastfed.²⁸

Although initiation rates of breastfeeding are important, continuation rates are more significant for maximum health benefits. The prevalence of breastfeeding at six to eight weeks is a national indicator of child health and wellbeing. Government policy, underpinned by NICE guidance,²⁹ promotes the adoption and implementation of the UNICEF Baby Friendly Initiative as the best evidence-based vehicle to raise levels of breastfeeding prevalence. This is a global accreditation programme aimed at introducing and maintaining best practice standards for breastfeeding in maternity and community health services.

The local picture

Through the East Sussex Local Area Agreement, the PCTs and its partners are committed to actions aimed at supporting parents to choose to breastfeed, initiate breastfeeding successfully and maintain breastfeeding exclusively for the first six months of their child's life. Promoting and supporting breastfeeding is also a priority of the East Sussex Maternity Services Strategy 2009–2012.

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.³⁰ Less affluent areas tend to have lower rates of breastfeeding, both at initiation and in terms of how long breastfeeding is continued. In addition, evidence states that UK breastfeeding rates are particularly low among disadvantaged white women, particularly teenage women, first-time mothers and lone parents.³¹

Priorities for the PCTs and its partners,

²⁶ *Implementation plan for reducing health inequalities in infant mortality: a good practice guide*. London: Department of Health, 2007.

²⁷ *Commissioning local breastfeeding support services*. London: COI. Department of Health, 2009.

²⁸ Horta, B., Bahl, R., Martines, J. & Victora, C. *Evidence on the Longterm Effects of Breastfeeding: Systematic Reviews and Meta-Analysis*. World Health Organisation, 2007.

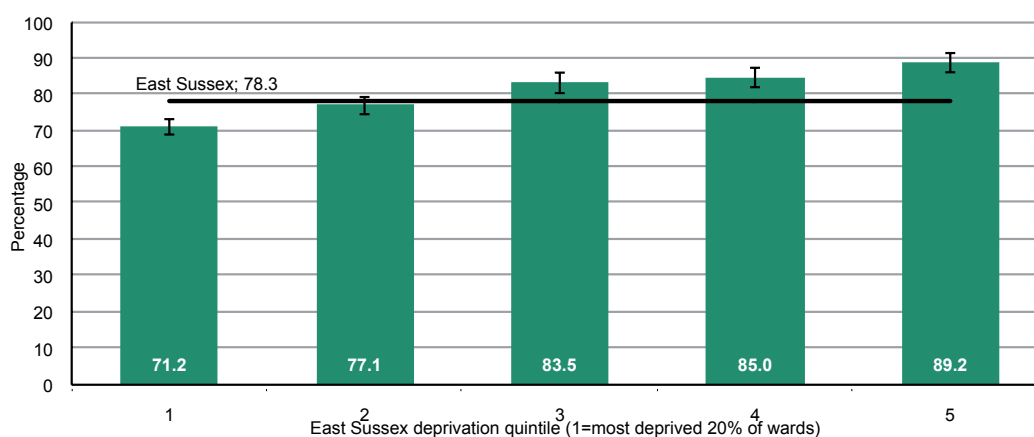
²⁹ *Improving the nutrition of pregnant and breastfeeding mothers and children in low-income households*. London: National Institute for Health and Clinical Excellence, 2008.

³⁰ *Breastfeeding Strategy 2009 – 2012*. NHS East Sussex Downs and Weald and NHS Hastings and Rother, 2009.

³¹ 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.

3 / How are we tackling Health Inequalities?

Figure 64: *Percentage of mothers initiating breastfeeding with 95% confidence intervals by deprivation quintile, East Sussex, 2008/09*



Source: Maternity units and IMD 2007

including the third sector, to improve and support breastfeeding include:

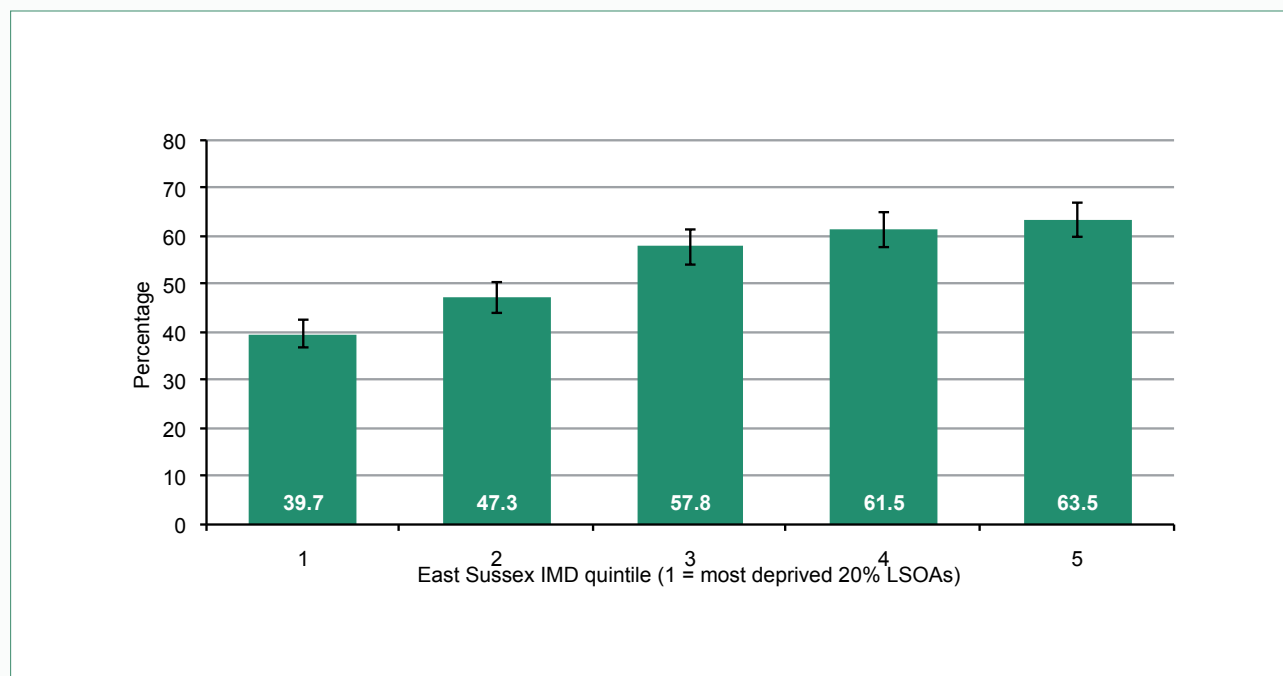
- ensuring all expectant and new parents are fully informed when making infant feeding choices;
- supporting mothers to initiate and sustain exclusive breastfeeding until their child is six months of age by identifying problems early;
- services should be multifaceted and should target mothers who are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

The NHS Priorities and Planning Framework 2003-2006 set a target to deliver an increase of 2 percentage points per year in breastfeeding initiation rates, especially for women from disadvantaged groups, to support a reduction in health inequalities.

The above figure indicates that there is almost a 20% difference (18%) between the most deprived mothers in East Sussex, in quintile 1, and the least deprived mothers, in quintile 5. The county average is 78.3%, which means that, across East Sussex, nearly eight in 10 mothers initiate breastfeeding, however only seven in 10 mothers initiate breastfeeding from the most deprived quintile, compared to nine in 10 in the least deprived quintile.

These differences are likely to be explained partially by knowledge and attitudes to breastfeeding. Conversely, there is minimal or no financial cost associated with breastfeeding; however, mothers from more deprived areas are typically less familiar with the associated health benefits and are more likely to have negative attitudes towards starting breastfeeding compared to those from less deprived areas. Other issues include support provided by partners, other family members and friends and the circumstances of the mother. If the mother is a single parent, or does not have the support from her partner and those around her, or also has other young children to care for, she may be less likely to breastfeed. These factors may be more common in women from less affluent areas.

Figure 65: *Prevalence of breastfeeding at 6–8 weeks amongst infants of known status with 95% confidence intervals, by East Sussex deprivation quintile, 2008/09*



Source: East Sussex child health systems and IMD 2007

There is clearly a relatively large drop-off in breastfeeding rates between initiation and maintenance at six to eight weeks across all quintiles. The drop off is 31% in the most deprived quintile and 25% in the least deprived quintile.

This means that the gap between the most deprived quintile and the least deprived quintile is slightly more marked when looking at breastfeeding rates when the baby is six to eight weeks old. There is a 24% difference between mothers in the most deprived quintile continuing to breastfeed their babies at six to eight weeks compared with mothers in the least deprived quintile. In the most deprived quintile, less than four in 10 mothers are likely to be breastfeeding, compared with over six in 10 in the least deprived quintile. Evidently, mothers need to initiate breastfeeding if they are to continue to breastfeed at six to eight weeks. In order to reduce inequalities, there should be a focus on encouraging mothers from more deprived groups to initiate breastfeeding, and then to support them to continue this.

What has worked well?

The capability and capacity of East Sussex health visiting teams to support breastfeeding was reviewed in 2009 and, as a consequence, a mandatory training programme was commissioned to enable frontline staff to give consistent advice and support to mothers.

Data collection of breastfeeding prevalence at six to eight weeks has been reviewed. The result of this process now means that data from health visitors can now be relied upon and can be used to measure the impact of interventions.

The peer support programme has been reviewed and arrangements have been put in place to provide supervision of volunteers.

Mental health

Within the new Child and Adolescent Mental Health Service strategy, we are now delivering a much more targeted programme in relation to reducing health inequalities.

A new service is being commissioned to work with Looked After Children who have planned permanency; i.e. are awaiting adoption. This service provides assessment and treatment to Looked After Children who have emotional and wellbeing difficulties.

We have also commissioned Brighton University to deliver resilience training to practitioners working across agencies to increase their skills in resilience when providing support/advice and care to our most vulnerable young people. We currently have 12 practitioners from social care, health and education undertaking this training.

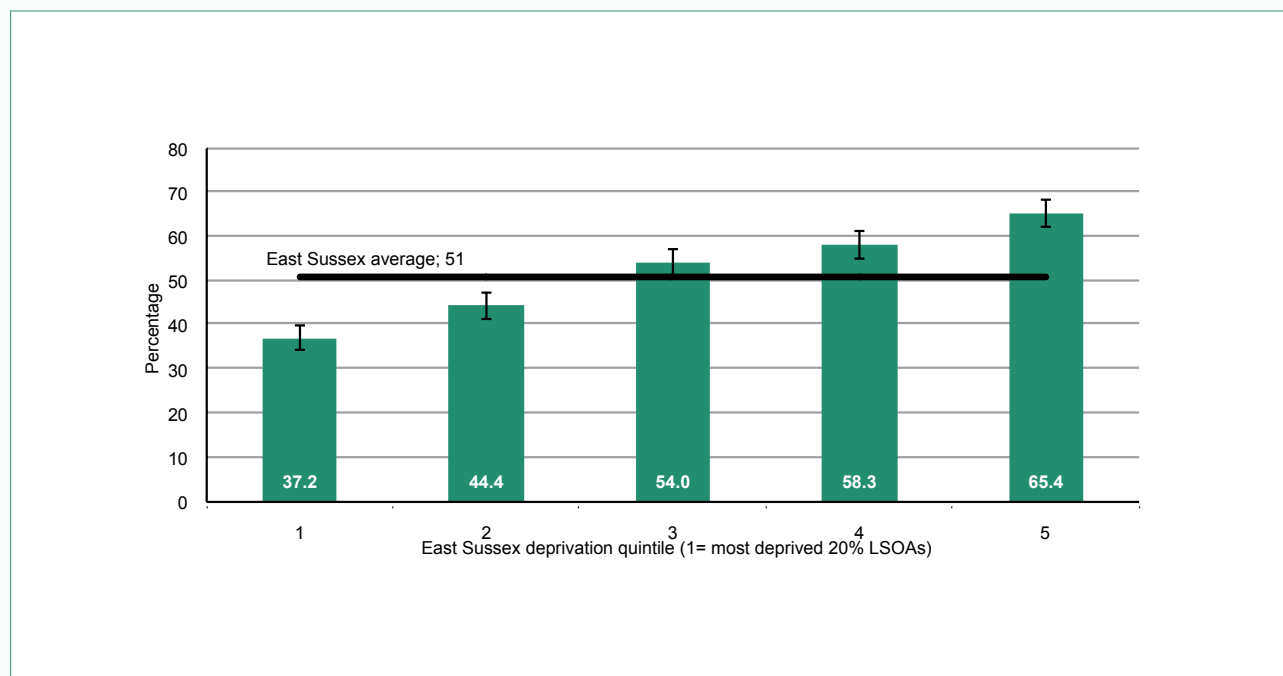
A new mental health practitioner has been funded to work within the care leavers team to provide mental health assessments on all young care leavers, to ensure their mental health needs are identified and interventions provided early.

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.

We have targeted mental health services in schools in the west of the county, as well as a one-year pilot, co-ordinating training and good mental health awareness across secondary and primary schools in Eastbourne.

The FNP have commissioned early intervention work on teenage parents and mental health.

Figure 66: Pupils achieving 5 A* to C grades for GCSE including English and Maths by deprivation quintile, East Sussex, 2008/09 academic year



Source: East Sussex County Council and IMD 2007

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.

The above figure indicates that, across East Sussex, just over half (51%) of pupils achieve 5 GCSEs, including Maths and English, at grade A–C. However, there are very clearly marked differences in attainment according to deprivation. In the most deprived fifth of the county (quintile 1), just over one in three pupils (37%) attain 5 GCSEs at A–C, compared with nearly two in three pupils (65%) in the least deprived fifth of the county (quintile 5).

These differences in educational achievement at GCSE level largely affect the life chances of pupils, especially in terms of the likelihood of continuing with education (especially academic education) post-GCSEs. In turn, this has a well-known impact on the ability to source meaningful employment (which is beneficial to health) and to secure the financial means required in order to live in housing that is not detrimental to health and to buy food that contributes to good health and wellbeing. All of these factors additionally impact on mental and emotional health, whereby a lack of, or poorly paid, employment, poor housing and poor diet all have a negative effect on mental and emotional, as well as physical health.

Reducing the gap in educational achievement at GCSE level is a key factor in reducing inequalities across East Sussex.

3 / How are we tackling Health Inequalities?

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. These include:

- promoting better take up of the Early Years Education Entitlement, particularly in areas of deprivation but also across rural areas, through the Children's Centre programme;
- targeted work across Children's Centres, primary schools and other services to ensure that children are ready for school by age five years, particularly in relation to communication skills and emotional and social development. This is a key aim in the Healthy Child Programme;
- targeted support for early years settings to help improve outcomes at the Foundation Stage (age five years);
- targeted support for schools across a range of areas, from leadership and management to aspects of the curriculum, to address under-performance;
- targeted support for groups of children and young people vulnerable to underachievement, including children and young people who are looked after or who have been excluded or who have special needs;
- work with schools to raise awareness of key research evidence about effective strategies for 'narrowing the gap' at local level;
- work with agencies across the Children and Young People's Trust partnership to raise awareness of the contribution which different agencies can make to improving standards of attainment;
- facilitation of partnerships between individual schools to drive improvement, for example, the Hastings Federation;
- in Hastings and Eastbourne, the development of academies with external sponsors;
- funding for out of school activities;
- support for Local Partnerships for Children, bringing together schools and local children's services to improve outcomes for children and young people across the board, including educational attainment. These partnerships have a strong focus on family support and supporting children at key transition points.

Next step

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.

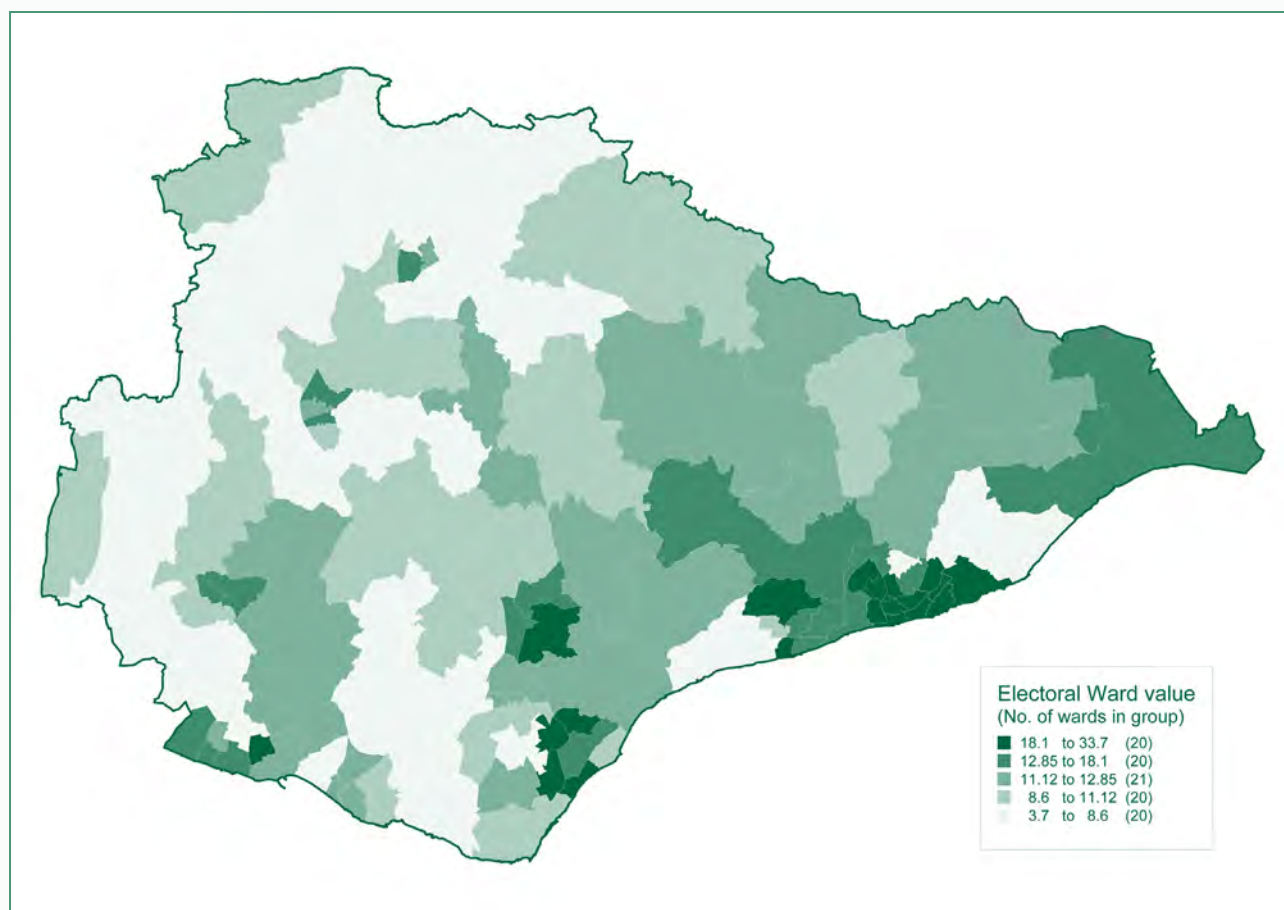
Older People

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. This section will not repeat that information, but rather present some of the key facts as the main focus is the new Older Peoples Joint Commissioning Strategy 'Living Longer, Living Well'. The Public Health Report last year explained that it was the final year of the 2007/10 Older Peoples Strategy and that work was under-way to develop a new joint commissioning strategy for older people from 2011. That work has now been completed.

Key facts

- The East Sussex population is older than the national profile, with almost 23% of the total population aged over 65 years. However, there is wide variation within East Sussex. There will be a continuous increase in the number of people aged over 50 years over the next 5–10 years.
- There is wide variation in the proportion of older people affected by income deprivation across East Sussex (Figure 67).
- 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, there is variation at district/borough level within East Sussex (Figure 68).

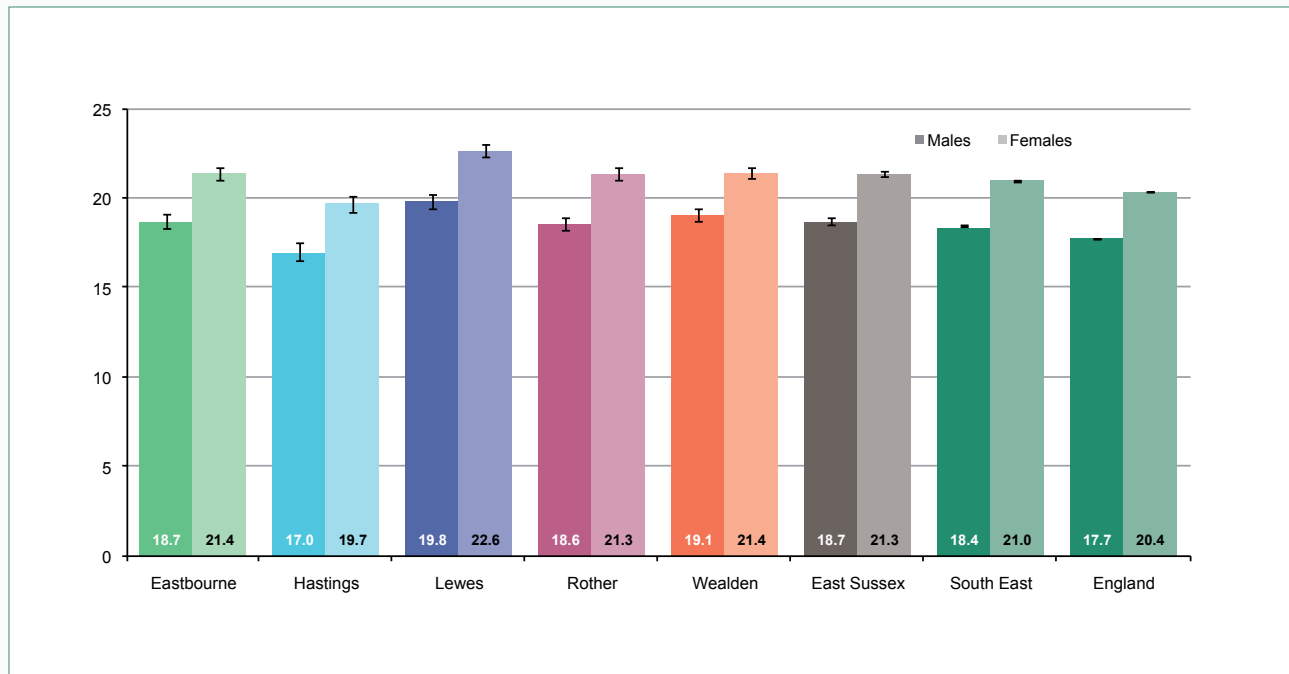
Figure 67: *Income Deprivation Affecting Older People Index (IDAOPI) 2007, East Sussex electoral wards*



Source: Index of Multiple Deprivation 2007

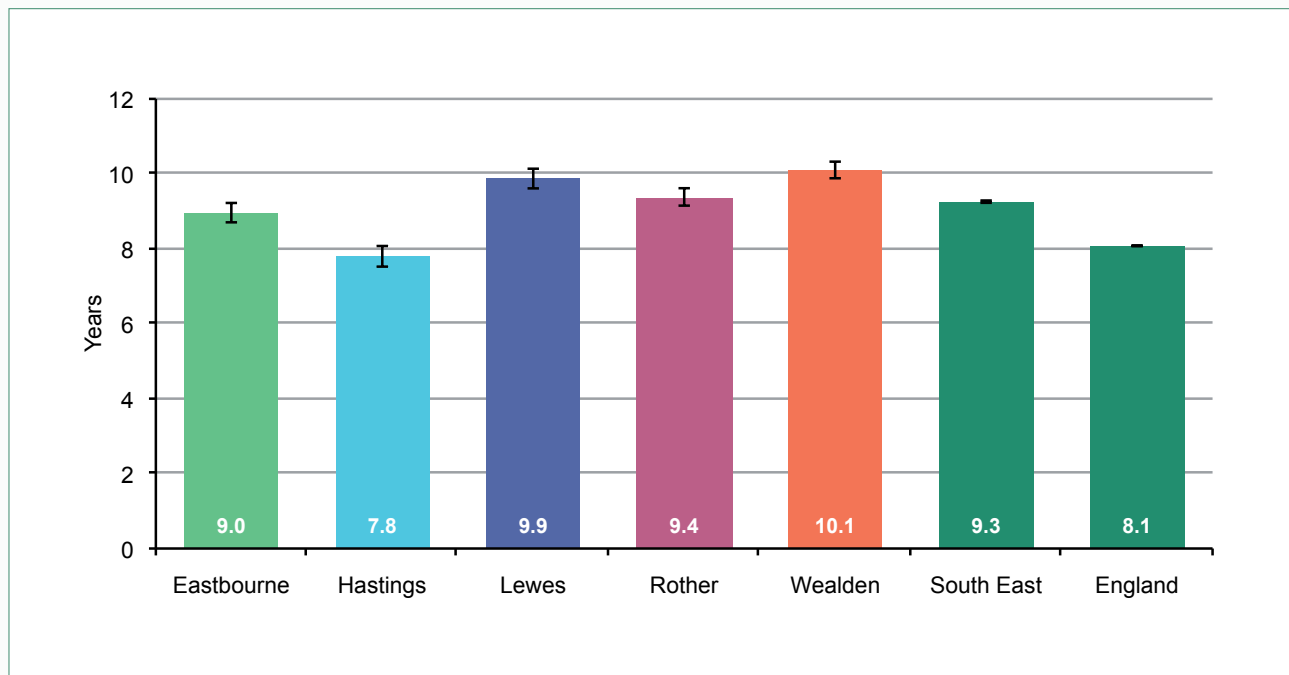
3 / How are we tackling Health Inequalities?

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



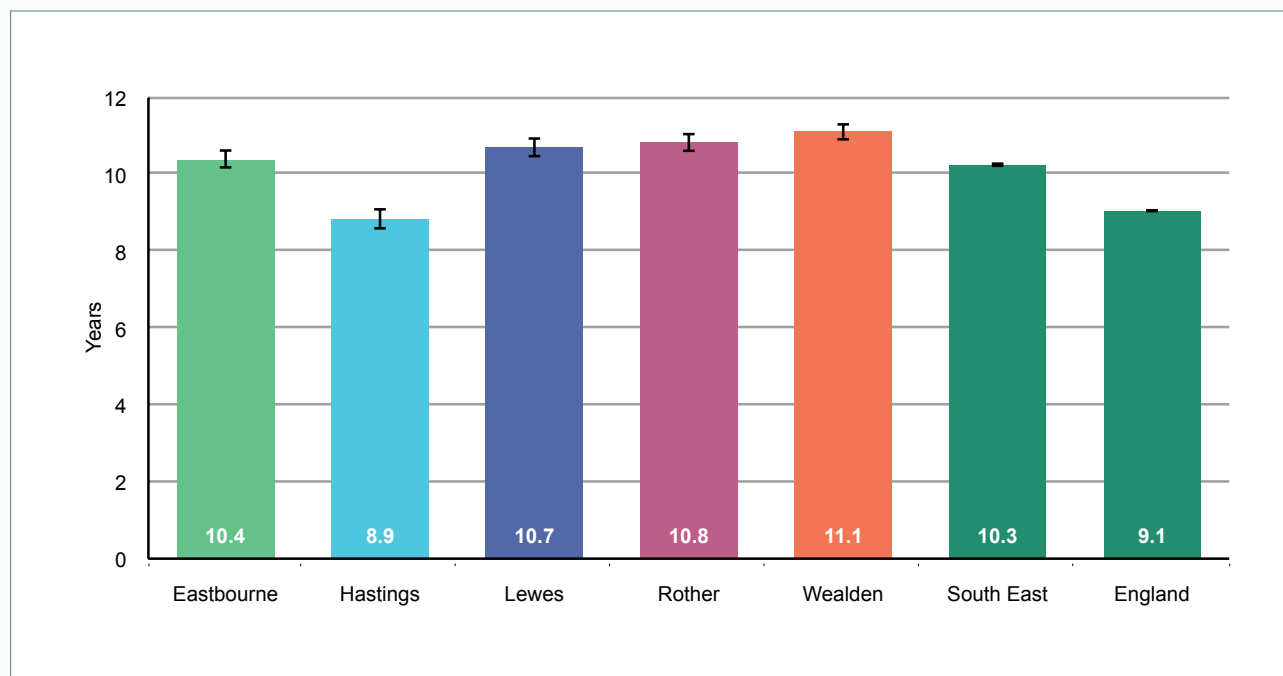
Source: Compendium of Clinical and Health Indicators

Figure 69: Disability-free life expectancy at age 65 years with 95% confidence intervals, males, East Sussex districts and boroughs, 1999–2003



Source: ONS

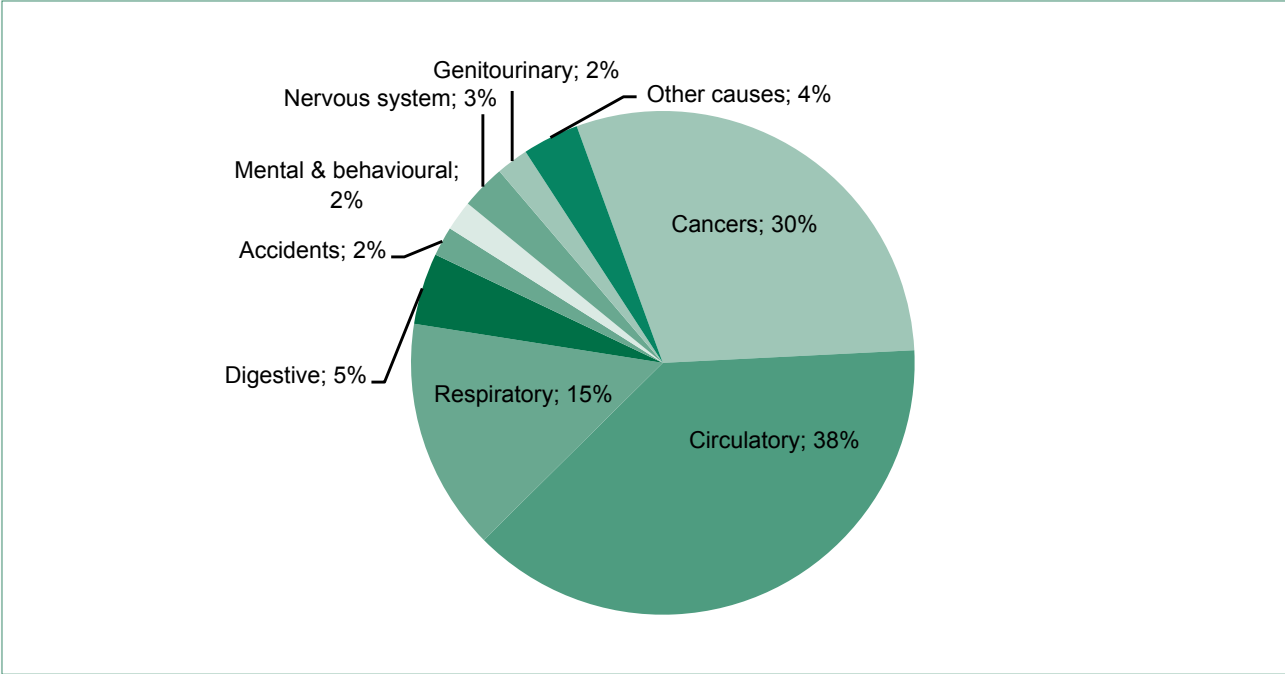
Figure 70: Disability-free life expectancy at age 65 years with 95% confidence intervals, females, East Sussex districts and boroughs, 1999–2003



Source: ONS

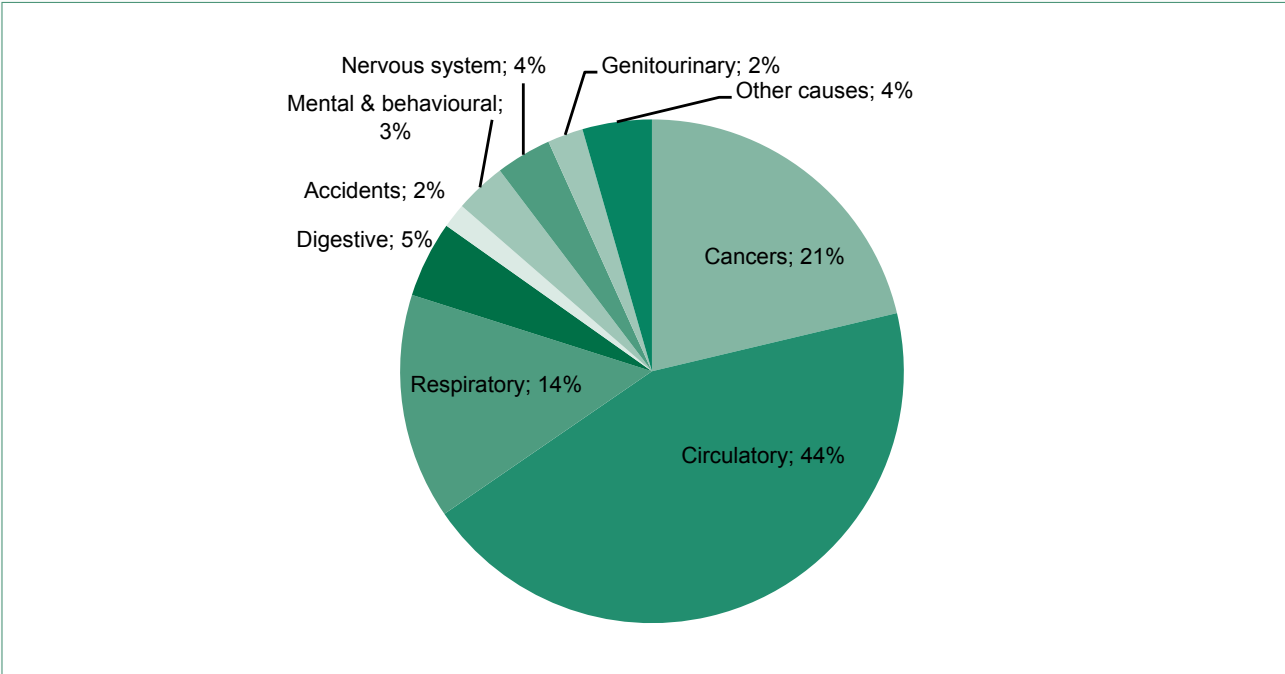
- Disability-free life expectancy defines healthy life as years free from limiting long-standing illness. This is based on a Census question; so, until we have the results from the 2011 Census, the 2001 Census information is the most current. All districts have significantly higher disability-free life expectancy at 65 years than England, except for Hastings (Figures 69 and 70). Disability-free life expectancy in Hastings is below the England average and significantly lower than the South East regional average.
 - 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 (Figures 71 and 72). Circulatory disease, including CHD and stroke, is the commonest cause of death in those aged 65 years and over in East Sussex. The mortality rate from CHD is significantly lower than it is for England. Mortality from stroke is low in East Sussex compared to the rest of England, with small variations across the districts and boroughs. Overall, the mortality from all cancers for people aged 65–74 is lower compared to the England average, and has been since 1993.
- Mortality from cancer is lower in women than men across all districts/boroughs in the county. Mortality from respiratory disease is associated with social inequalities and is much higher in Hastings. Falls and accidents are a comparatively low cause of mortality when seen alongside circulatory diseases and cancer. Mortality from accidents, which includes falls, is significantly higher than the England rate in Eastbourne district.
- 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 life to years.

Figure 71: Causes of death among males aged 65 years and over resident in East Sussex, 2008



Source: Vital Statistics, ONS

Figure 72: Causes of death among females aged 65 years and over resident in East Sussex, 2008



Source: Vital Statistics, ONS

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, 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.

To assist in implementing the strategy a model of health, care and housing support has been developed that builds on the 'care pathway' approach developed in the previous strategy (2007/10) and illustrates some of the services that people can access. The care pathway has been helpful in recognising that people may need different services at different stages of their life and also that people may move from one stage to another and back again, depending on their needs.

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.

Older people's ability to access and manage sufficient income to support their basic living requirements is also essential. Low income is associated with poorer health, housing and limited access to transport, which can lead to increased social isolation. The current financial recession has had a big impact on the retired population with fixed incomes, and those relying on interest from savings have seen their income reduce significantly over the last 18 months. This illustrates the importance of planning for retirement for those who are now 50-plus and the need to consider a range of financial support options for when they retire.

The number of people accessing benefits also gives an indication of those living on low incomes. 'The Income Deprivation Affecting Older People Index' (IDAOPI) measures the proportion of people aged 60 and over in receipt of benefits (and their partners, if over 60). There is a wide variation between the districts and boroughs, with the highest percentage in Hastings and the lowest in Wealden.

3 / How are we tackling Health Inequalities?

The type of housing and the conditions in which people live has a significant impact on their health, care and housing support needs. The quality of housing, such as disrepair and lack of heating, are recognised as significant factors in measuring deprivation and health, care and housing support needs. Older people living on their own may also be at risk of poorer mental and physical health.

Future commissioning for older people needs to take account of the following key issues:

- The key facts at the start of this section.
- Adults in later life living in rural areas are less likely to have access to a range of services and transport in comparison to people living in towns and urban areas.
- 5.2% of people of pensionable age are from BME backgrounds and may develop age-related illnesses at an earlier age. They are more likely to be socially isolated due to the lack of community networks.
- Recommendations from the 'Comprehensive needs Assessment for Black and Minority Ethnic Groups (Including Gypsies and Travellers) in East Sussex' 2010 (see Chapter 2).
- A variation of the proportion of people living on benefits across East Sussex (this can be an indicator of low income).
- The current financial recession has had a great impact on the retired population with fixed incomes and those relying on interest from savings seeing their income reduce significantly over the last 18 months.
- 47% of people of pensionable age live on their own and may be at risk of poorer mental and physical health.
- As people get older they tend to experience more health and social care issues, including long-term conditions such as diabetes and COPD, and therefore use services more frequently.

- There will be an increasing number of people who suffer from dementia and mental health illnesses such as depression as they grow older.
- Carers play a significant role in supporting adults in later age and the majority are in this age group. They are more prone to increased health and social care problems due to social isolation and stress experienced through their caring role.
- Over half the retired population are owner-occupiers, many of whom are equity rich and cash poor.
- The number of people receiving services funded by Adult Social Care has increased year-on-year over the last 3 years and, based on population projections and future needs, will continue to do so.
- Over the last 3 years, an increased use of community services, short-term intensive care and support and the reduction in long-term care shows a significant shift towards supporting more people to stay independent and living at home as long as possible, as well as a more effective use of resources.
- Emergency hospital admissions are highest among adults in later life and increase with age.

A range of key actions have been agreed that will underpin the implementation of the strategy by focusing on the four key priorities. All priorities acknowledge the needs of a diverse ageing population in the county and promote equality. Additionally, there is an implicit intention to promote economic wellbeing throughout the range of actions.

Priority One – Develop and improve the range of community services to promote independence and wellbeing

This will be achieved by:

- Improving access to information and advice on a range of services available in the community.
- Continuing to utilise the information from the Joint Strategic Needs Assessment by focusing on priority areas and tackling health inequalities.
- Continuing to work with all adults in later life and their carers to develop and improve services and improve the service user and carer experience.
- Further developing joint strategies and services for improving the health and well being of adults in later life and their carers.
- Modernising personal home care services and the range of day opportunities in order to provide more choice and personalised services.
- Continuing to work with partners in the voluntary and community sector to further develop preventative services, social opportunities and increase social capital.
- Improving access to, and the range of, community transport across East Sussex in relation to improving access to services in social and health care settings.
- Offering 30% of adults a personal budget by March 2011 and an opportunity to access support and brokerage services to support them in both planning and accessing a range of services.
- Launch a 'Support with Confidence' scheme to provide a directory of services that meet quality and safety standards.
- Establish a provider forum for adults in later life between the statutory, independent and voluntary and community sectors to effectively work together to improve and develop services in line with strategic commissioning priorities and outcomes.
- Continuing implementation of the Quality of Life Strategy 'Time of our Lives' and action plan.
- Regularly reviewing the Department of Health-funded pilot carers demonstrators' sites on the carer's pathway between primary and secondary care services, provide flexible respite for carers of people with dementia and ensure we apply national learning to the East Sussex project.
- Providing programmes of carer's respite opportunities across the county.
- Continuing to provide Telecare services as preventative support or in complex packages of care but review the spend to ensure the ongoing model will be sustainable.
- Developing and commissioning a new model of community equipment service(s) offering fairer and timely provision.
- Developing a county-wide short-term floating support service and encouraging local older people to use communal activities in sheltered housing schemes.
- Establishing an easy-to-access community alarm service.

Priority Two – Develop and improve accommodation options, with more community-based services and supported housing

This will be achieved by:

- Developing 'extra care' housing schemes in priority areas and reviewing services in existing 'extra care' housing schemes to inform future developments.
- Building on priorities identified in locality housing and support strategies through the development of the county-wide Supported Housing Development Strategic Plan.
- Developing a home-share initiative in partnership with district and borough colleagues.
- Continuing to fund flexible onsite housing support in sheltered housing.
- Supporting the development of handyperson services across East Sussex following the evaluation of the handyperson grant pilot project.
- Developing the First Stop pilot to improve access to housing-related information and advice.
- Exploring the development of a housing options service to provide advice and practical ongoing support to people to enable them to access accommodation to meet their needs.

3 / How are we tackling Health Inequalities?

Priority Three – Develop and improve the range of community services for those who have urgent, transitional or ongoing complex needs

This will be achieved by:

- Implementing the objectives identified in the Joint Intermediate Care Strategic Framework (2009) through a detailed work programme.
- Aligning health and social care community services to meet the varying needs of adults who have ongoing complex needs and those who need urgent or transitional care in the most effective way.
- Centering services around the people in local areas, for example, groups of GP practices.
- Implementing the Joint End of Life Care Strategy, which will aim to provide a more joined-up approach across East Sussex to those who have been diagnosed with a life-limiting illness.
- Developing an integrated care and support strategic framework for the management of adults with long-term conditions.
- Implementing all health strategies, including falls prevention and bone health, urgent care, stroke and long-term conditions, to optimise services within a community health or home setting.

Priority Four – Develop and improve the range of services for people with dementia and functional mental health issues

This will be achieved by:

- Raising awareness and reducing the stigma of dementia to encourage early identification.
- Redesigning the East Sussex Dementia Care Pathway in line with the National Dementia Strategy recommendations.
- Increasing access to Memory Assessment and Support Services throughout the county. Engaging with primary and acute care settings to maximise their contribution to meeting the objectives in the National Dementia Strategy.
- Increasing numbers of those being diagnosed with dementia as early as possible.

- Expanding the Older People's Mental Health Liaison service to support both acute and intermediate care services to continue to provide quality care for those with organic and functional mental health issues.
- Implement the provision of an 'Age Appropriate' functional Mental Health Service.
- Regularly reviewing the Department of Health-funded pilot demonstrators' site to provide support and advice to carers of people with dementia and ensuring national learning is applied.

Next steps

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 across health and social care should be balanced between locating them in areas with the 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.

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 of the slide is composed of three distinct geometric regions. The top region is a solid light blue color. Below this, a dark green shape enters from the left and tapers to a point on the right edge. The bottom region is a solid light green color that fills the rest of the space below the dark green shape.

Health inequalities are longstanding, deep-seated and have proved difficult to reduce. This final chapter will identify actions that we can expect to make an impact in a short timescale and actions 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 and 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. There is little more to say except that we must get better at promoting healthy lifestyles and commissioning more effective and targeted services to support healthy lifestyles.

Access to Services

This report so far has not considered access to services, so this final chapter will examine access to the services that are provided by general practices. In doing that, it will draw on the work of the Health Inequalities National Support Team (HINST), which was set up by the Department of Health in 2007 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. It produces national guidance on improving delivery through high-impact changes, the promulgation of best practice and the identification of emerging themes.

The HINST has published a range of information, resources and tools, including a series of 'How to Guides' and 'Masterclass Reports'. The resources are built around good practice identified through visits to local areas which is expected to make an impact in **the short term** if delivered at a sufficient scale. We have also seen from Chapter 2 of this report that the main contributors to the life-expectancy gap across East Sussex are circulatory diseases, cancer and respiratory diseases, so there will also be a focus on CHD, cancer and COPD in this chapter.

The Wider Determinants of Health

This report started with a simple discussion about what health inequalities are and explained the significance and impact of the wider determinants of health. Therefore, this chapter will return to the wider determinants of health for a more detailed discussion about what the PCT and local government with other partners can do to reduce health inequalities. Those actions that are expected to make an impact in the **medium to long term**.

Quality In General Practice

General practitioners provide the main access point to health care. The HINST has stated that it has encountered clear examples in which 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 in general practice

The most widely accepted definition of poor performance is that proposed in *Supporting Doctors, Protecting Patients*³² which suggests that:

‘Failure to meet accepted standards of professional practice in medicine is not common but when it does occur it can be manifested in different ways. For example, poor clinical performance can be associated with errors or delays in diagnosis, use of outmoded tests or treatments, failure to act on the results of monitoring or testing, technical errors in performance of a procedure, poor attitude and behaviour, inability to work as a member of a team or poor communication with patients. In some cases, several of these aspects of poor performance may be present in one doctor’s practice. In other cases, there may also be underlying ill-health problems contributing to his or her failure to perform to an acceptable standard.’

The PCTs in East Sussex have in place robust arrangements for the purpose of 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. Figure 73 shows all GP performance referrals, since 2003, per 100,000 registered population by deprivation quintile.

We have found no association between GP poor performance and deprivation.

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. These are reviewed annually by an independent UK-wide expert group who consider latest evidence and recommend changes required in the light of changes to the evidence base, advances in health care and changes in legislation or regulation, etc.

It is important to note that participation in QOF is voluntary and practices will have adopted different strategies towards QOF, taking into account previous priorities and performance. All of the practices in East Sussex take part in QOF.

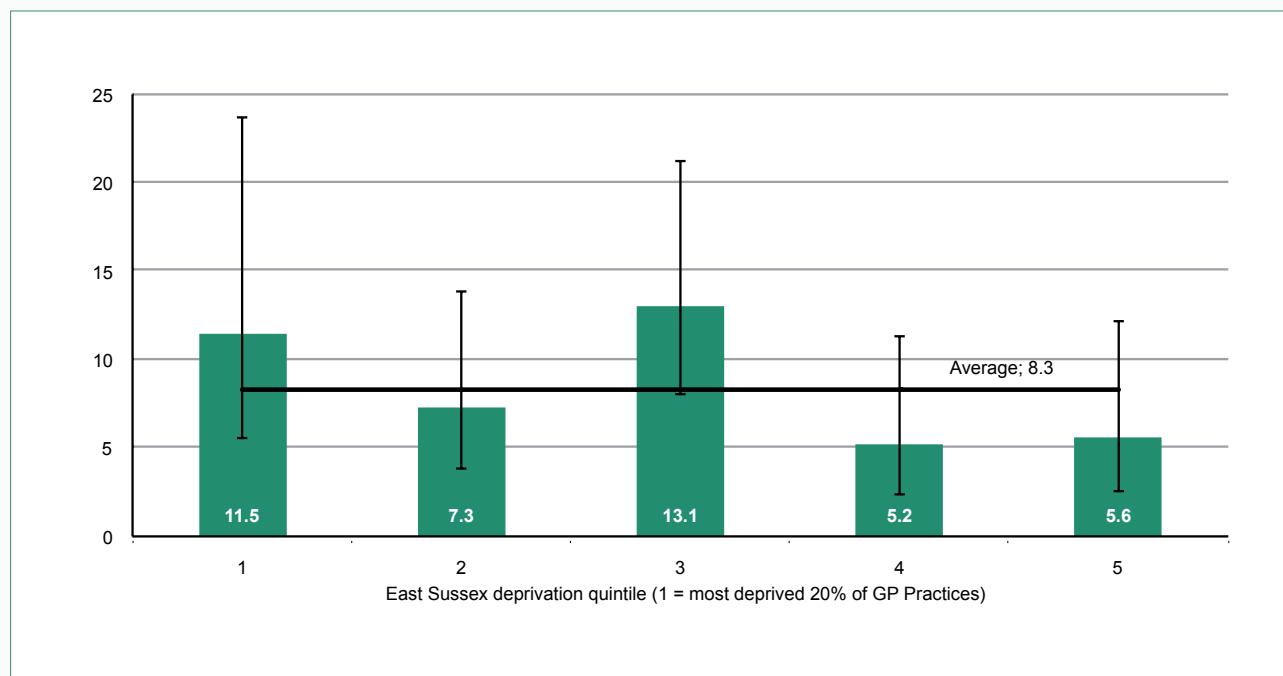
Clinical indicators cover different areas of clinical care such as:

- **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.

³² *Supporting Doctors, Protecting Patients*. London. Department of Health, 1999.

Figure 73: Performance referrals per 100,000 registered population with 95% confidence intervals by deprivation quintile, East Sussex, 2003–2010



Source: NHS ESDW and NHS H&R and IMD 2007

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.

A critical element to achieving optimal population health outcomes is to ensure that disease registers are comprehensive. They offer the potential to systematically improve the outcomes from the evidence-based treatment of patients on a scale that could enable the individual patient quality improvements to add up to a population-level change.

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 offer is 'one size fits all'. Developing tailored menus of options for patients can potentially make a considerable impact on inequalities in access and outcomes.

4 / How can we achieve more and move forward faster?

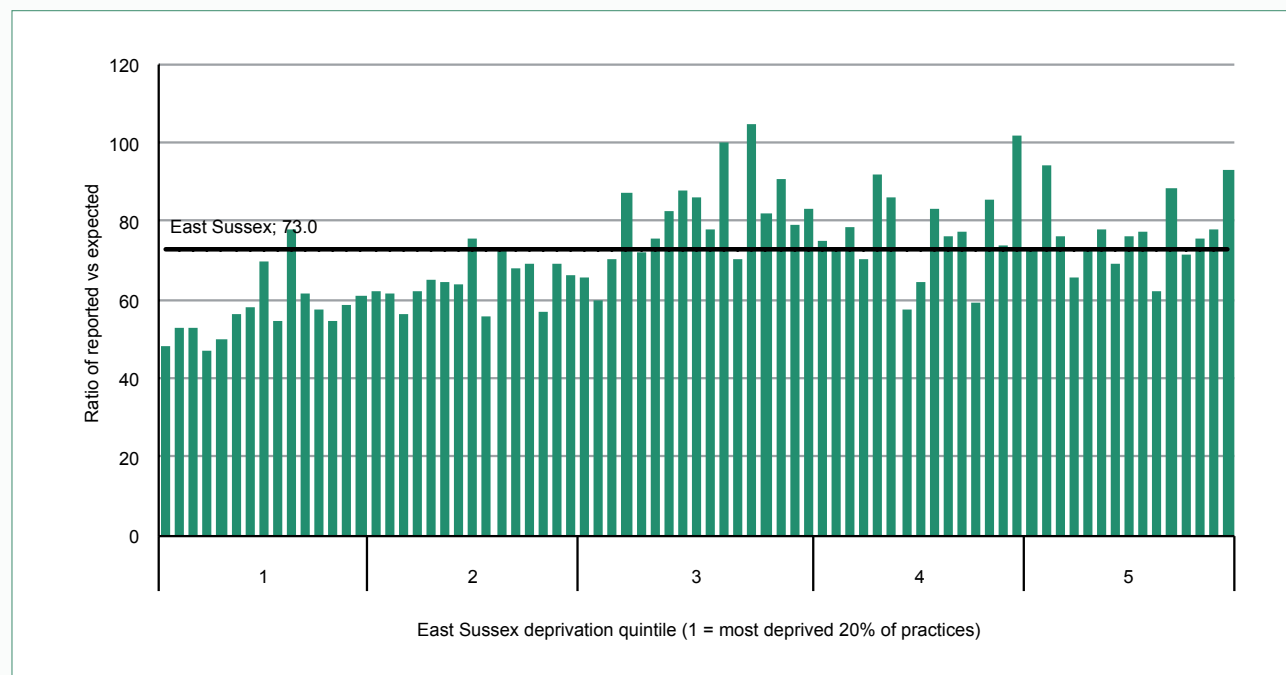
By using prevalence models to identify gaps between expected and actual numbers of people on disease registers, it is possible to identify practices where more systematic work is necessary to identify those at high risk through practice records or by outreach into communities, and to support them to attend for screening and possible treatment. We have undertaken this work as part of the JSNA programme. For CHD, cancer and COPD the figures below first show 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.

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).

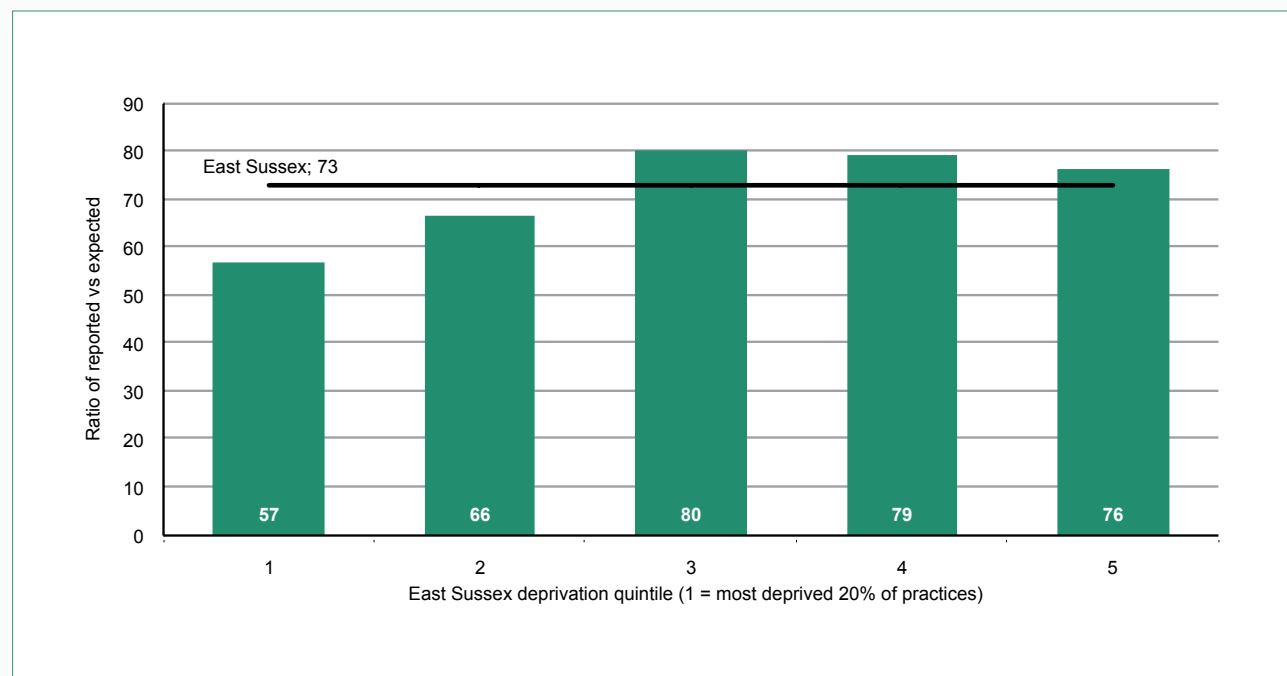
For cancer (Figures 76 and 77), while the ratio of GP reported versus expected prevalence is much higher, the same variation across practices is seen. Figure 77 also shows some association with deprivation with the lowest ratio in the most deprived quintile. The second and third quintiles also have lower ratios than the fourth and fifth quintiles.

Figure 74: Practice prevalence of CHD based on GP QOF Registers, 2008/09 versus expected prevalence of CHD by deprivation quintile, East Sussex



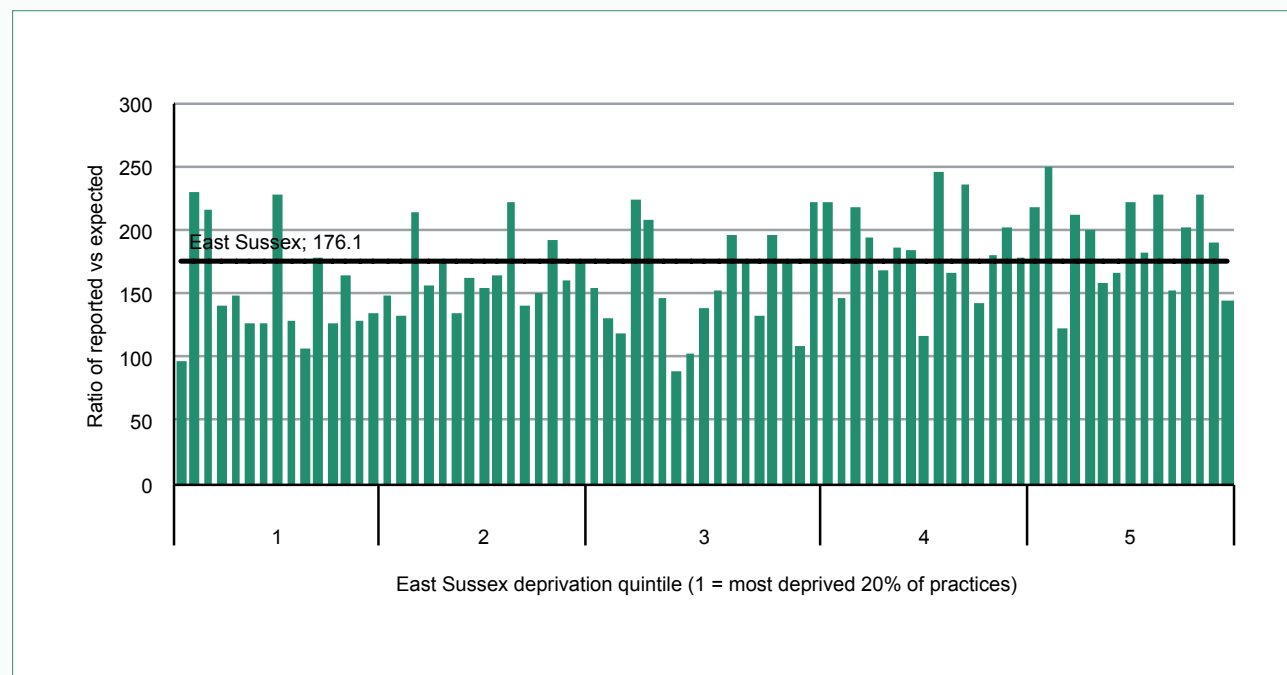
Source: NHS Comparators, Information Centre and IMD 2007

Figure 75: Prevalence of CHD based on GP QOF Registers, 2008/09 versus expected prevalence of CHD by deprivation quintile, East Sussex



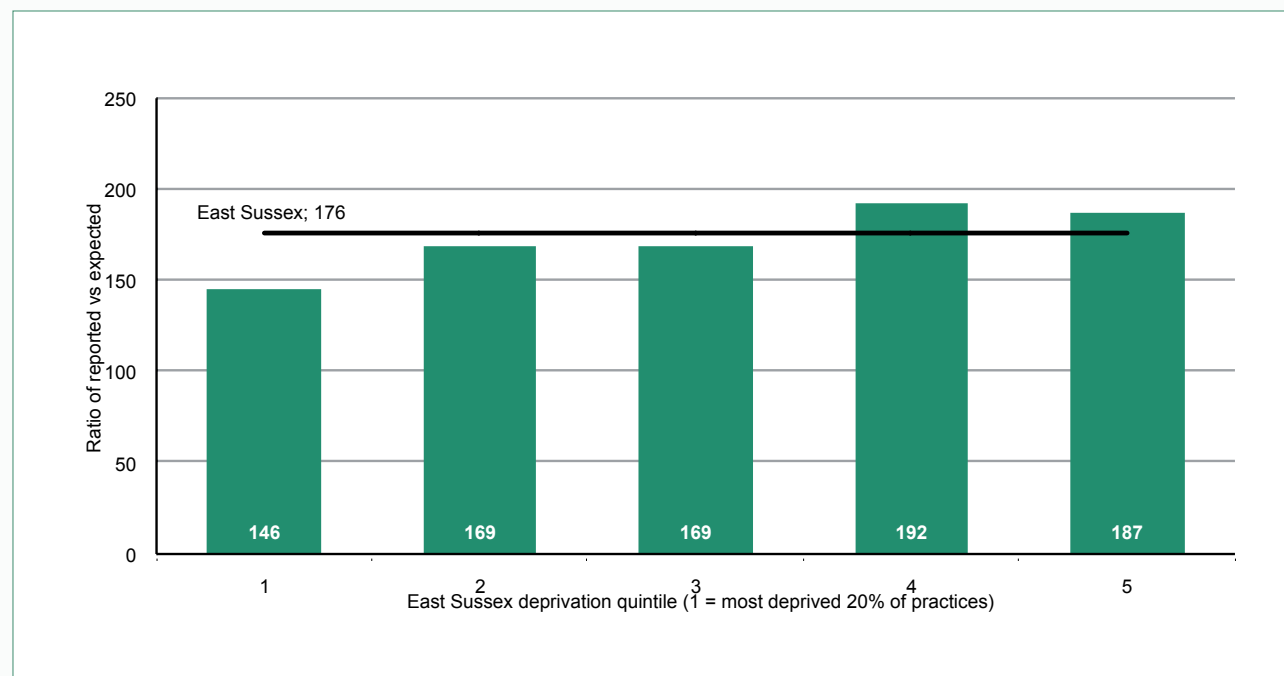
Source: NHS Comparators, Information Centre and IMD 2007

Figure 76: Practice prevalence of cancer based on GP QOF Registers, 2008/09 versus expected prevalence of cancer by deprivation quintile, East Sussex



Source: NHS Comparators, Information Centre and IMD 2007

Figure 77: Prevalence of cancer based on GP QOF Registers, 2008/09 versus expected prevalence of cancer by deprivation quintile, East Sussex

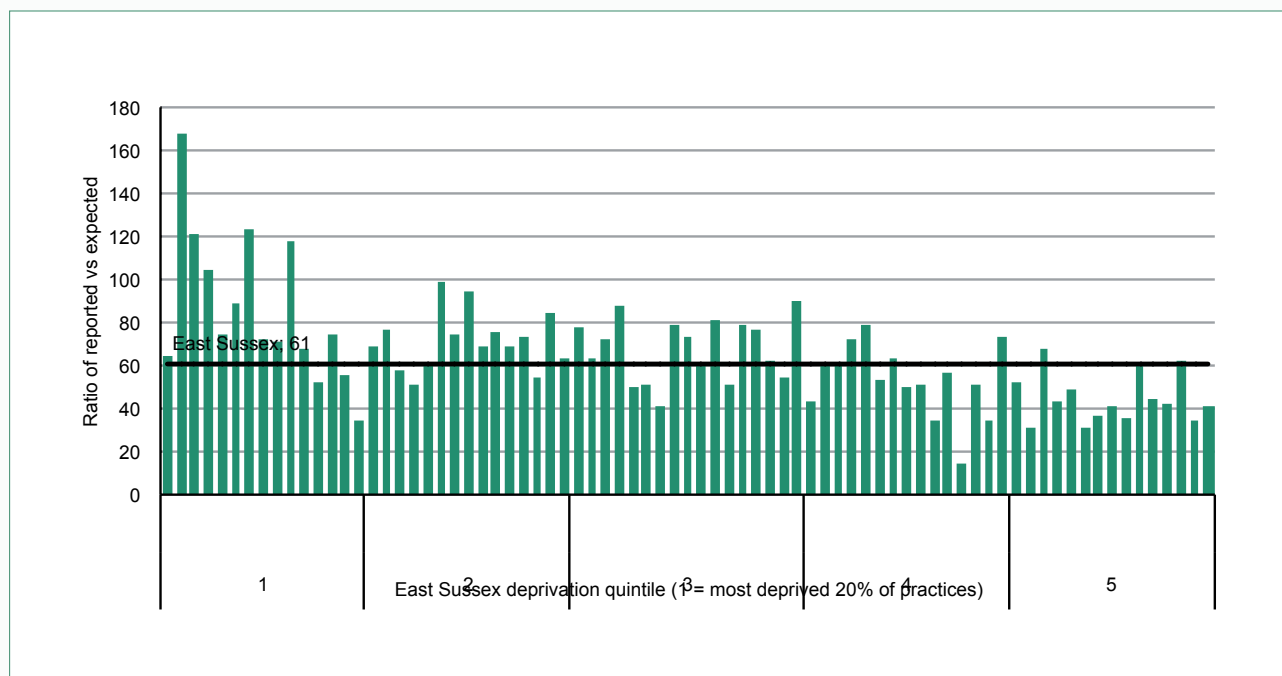


Source: NHS Comparators, Information Centre and IMD 2007

For COPD too, there is considerable variation between practices in the ratio of reported versus expected prevalence. Figure 78 shows a strong inverse association with deprivation – the more deprived the quintile the higher the ratio. Eighty percent of expected prevalence of COPD is reported in the most deprived quintile, reducing to 42% of expected prevalence reported in the least deprived quintile.

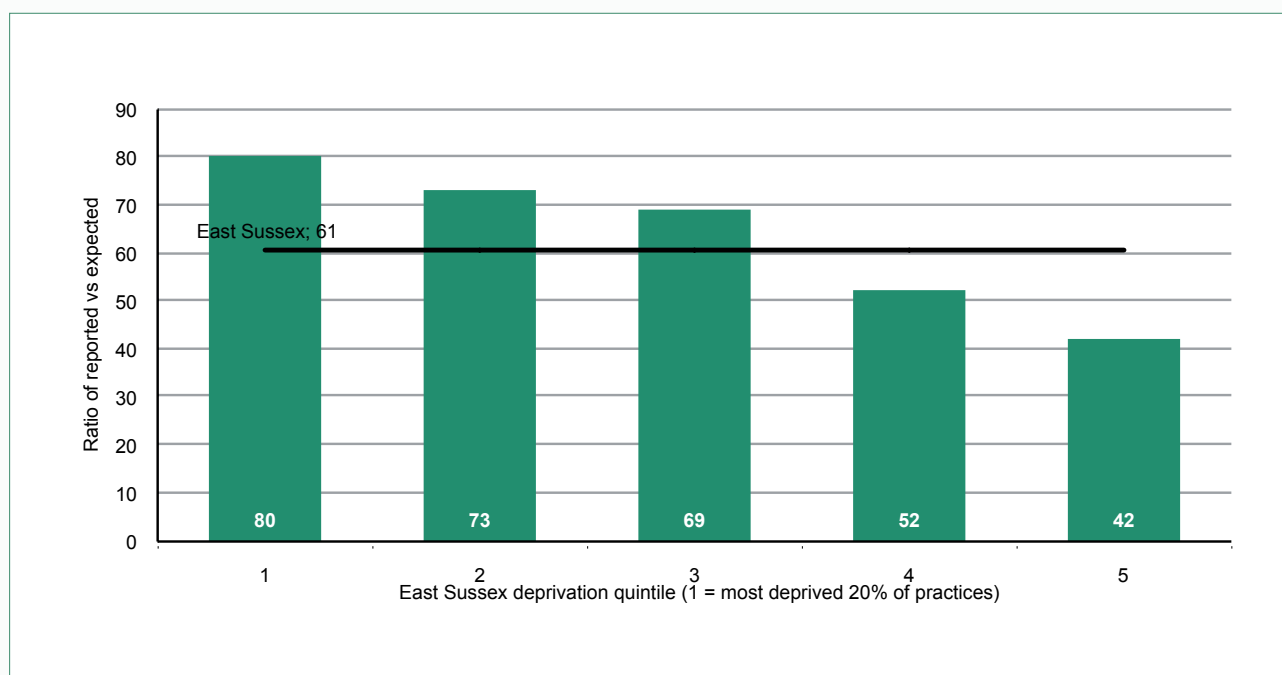
We have explored this further by looking at recorded CHD, cancer and COPD QOF prevalence in relation to mortality.

Figure 78: Practice prevalence of COPD based on GP QOF Registers, 2008/09 versus expected prevalence of COPD by deprivation quintile, East Sussex



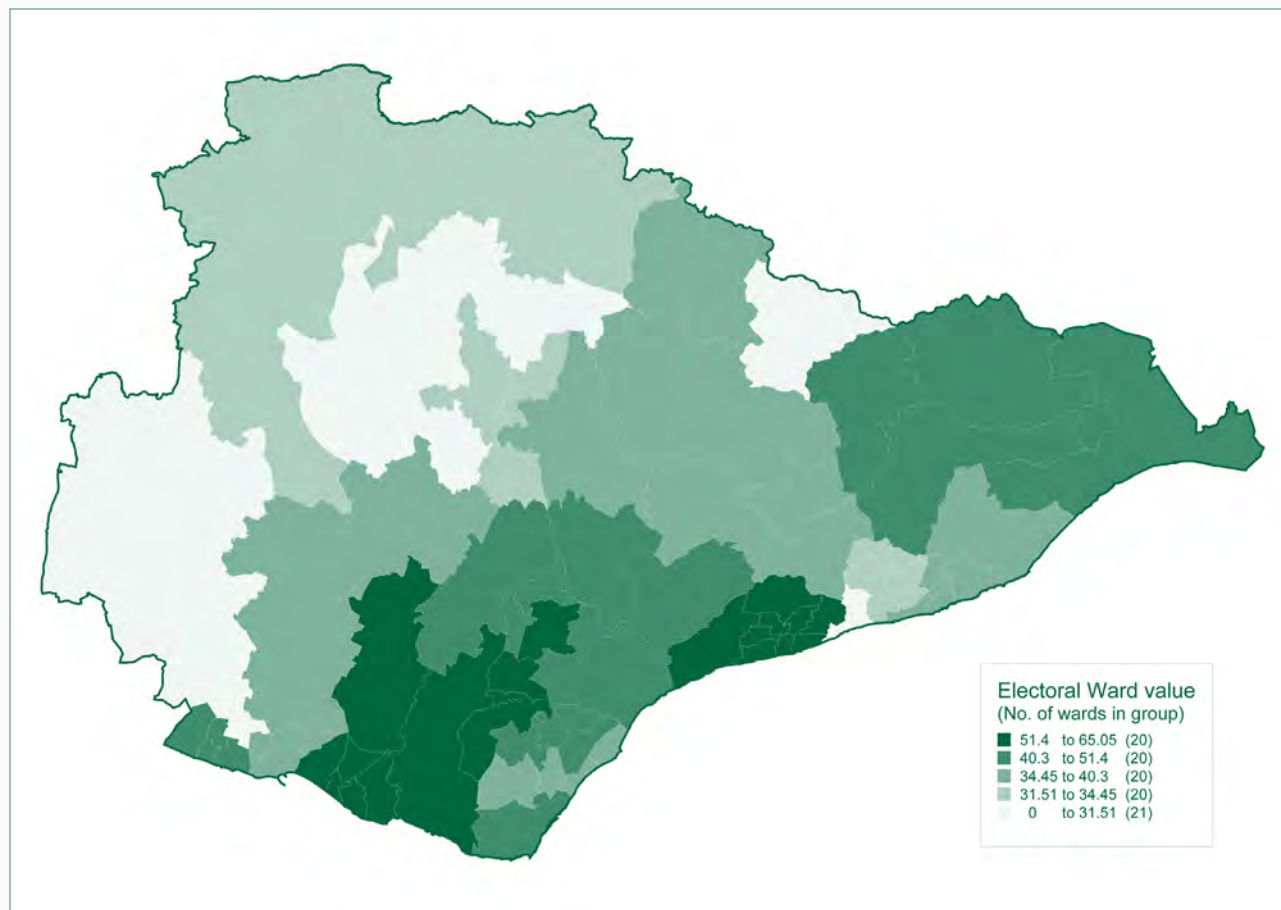
Source: NHS Comparators, Information Centre and IMD 2007

Figure 79: Prevalence of COPD based on GP QOF Registers, 2008/09 versus expected prevalence of COPD by deprivation quintile, East Sussex



Source: NHS Comparators, Information Centre and IMD 2007

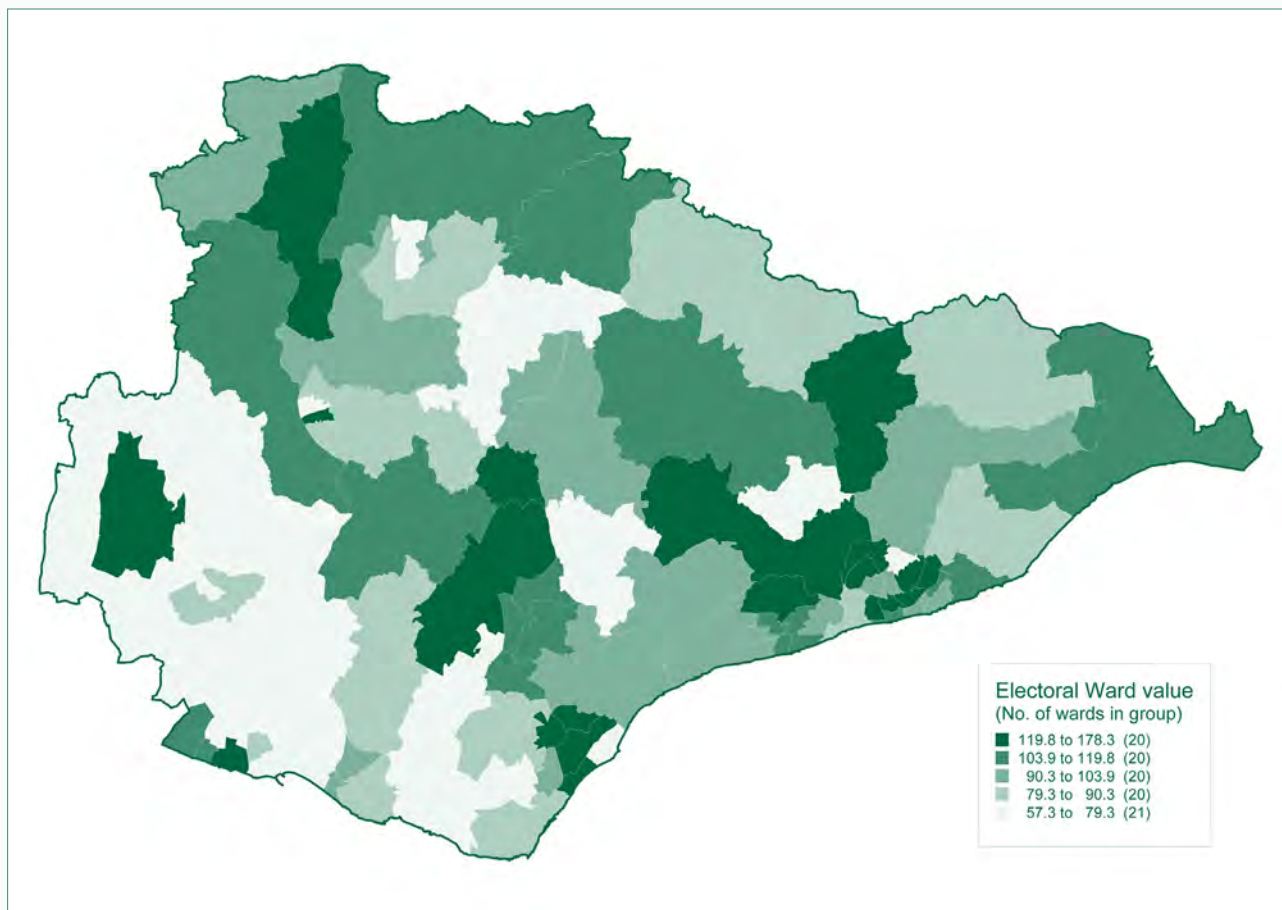
Figure 80: GP reported CHD prevalence, rate per 1,000 population, GP practice data modelled to electoral wards, 2007/08



Source: QOF data

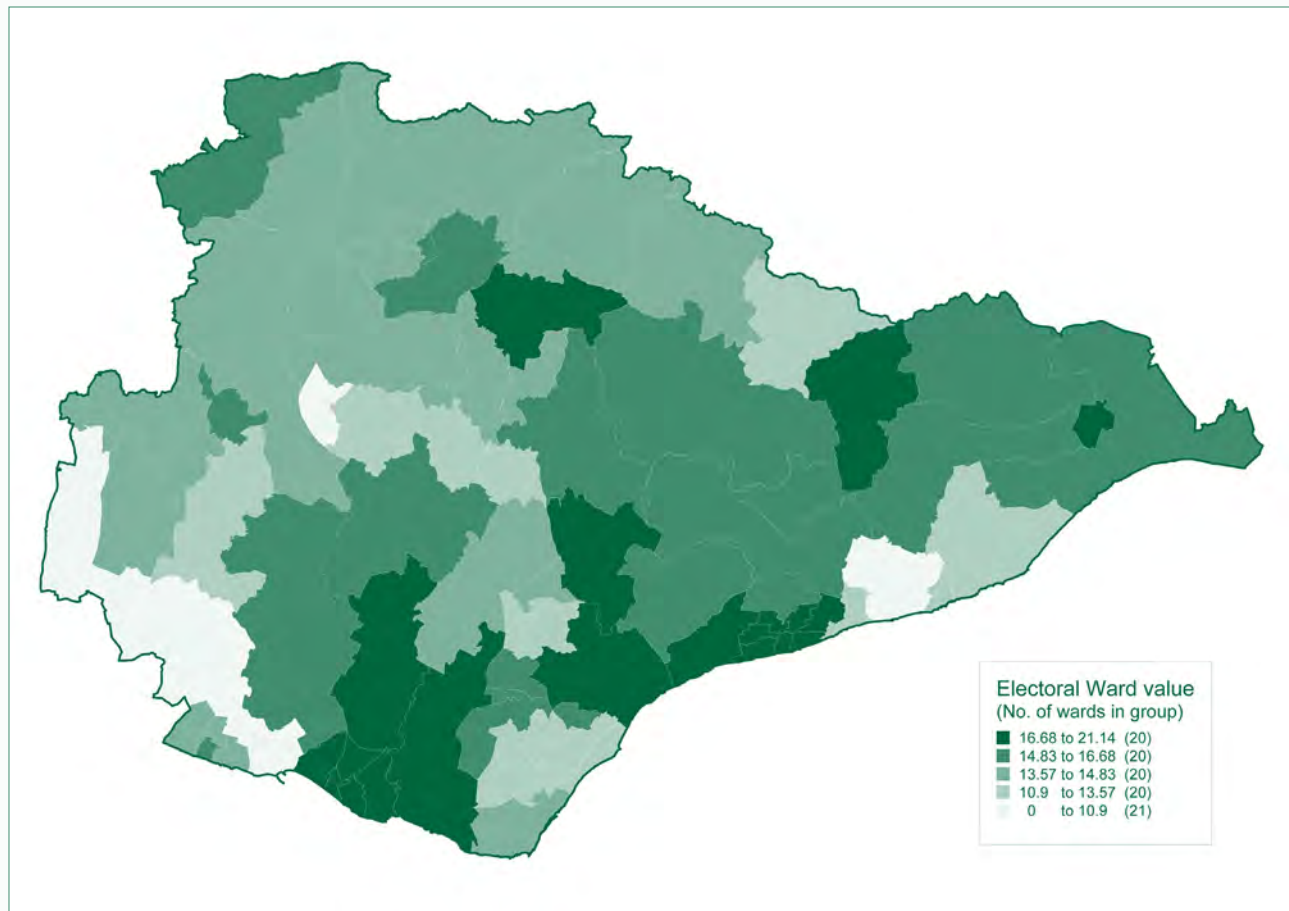
Figure 80 shows the prevalence and Figure 81 the mortality ratio for CHD across the county. The maps clearly demonstrate the difference between where those who are at risk of dying of CHD live, based on primary care register prevalence data (Figure 80), and actual mortality ratios taken from data in public health mortality files (Figure 81).

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



Source: ONS mortality data

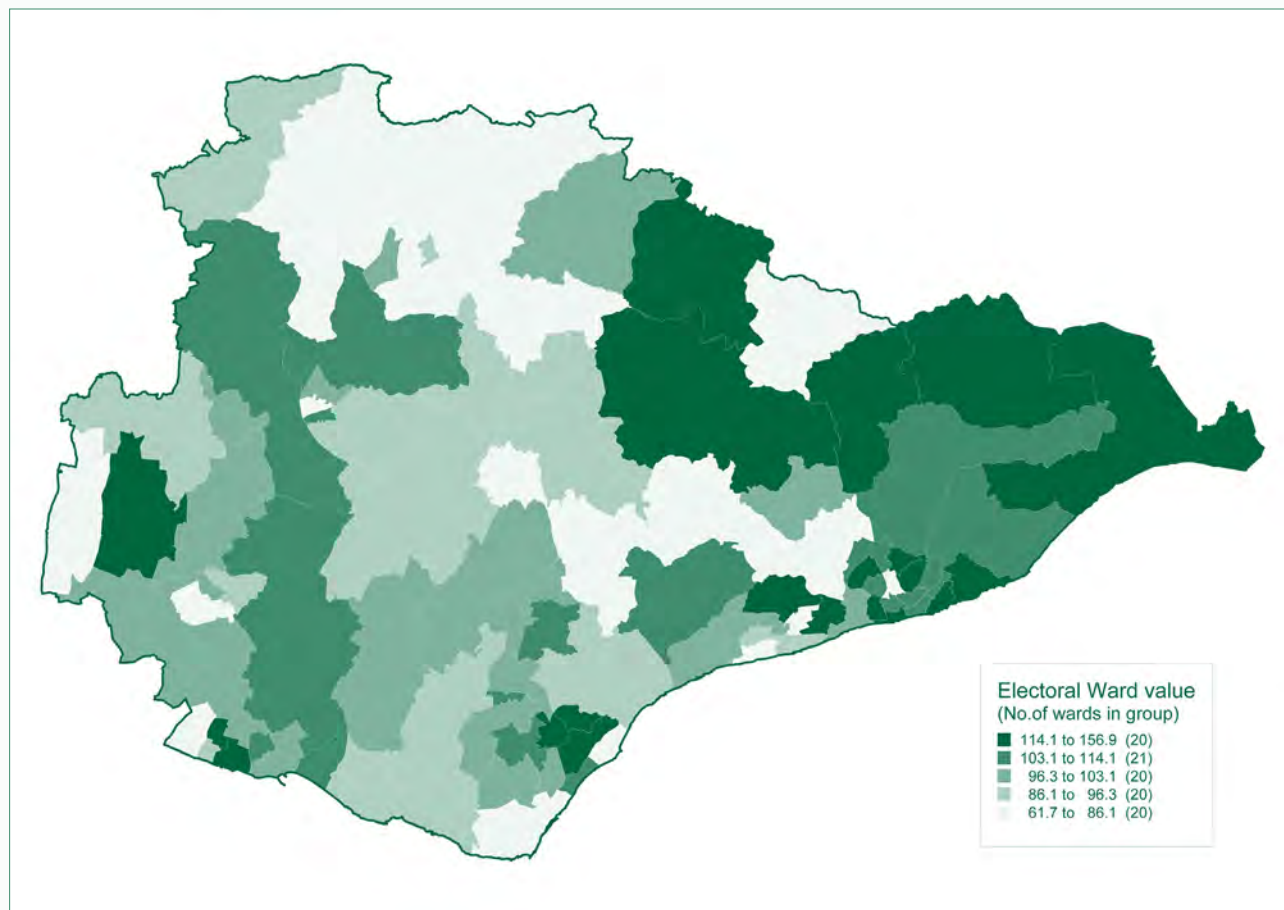
Figure 82: GP reported cancer prevalence, rate per 1,000 population, GP practice data modelled to electoral wards, 2007/08



Source: QOF data

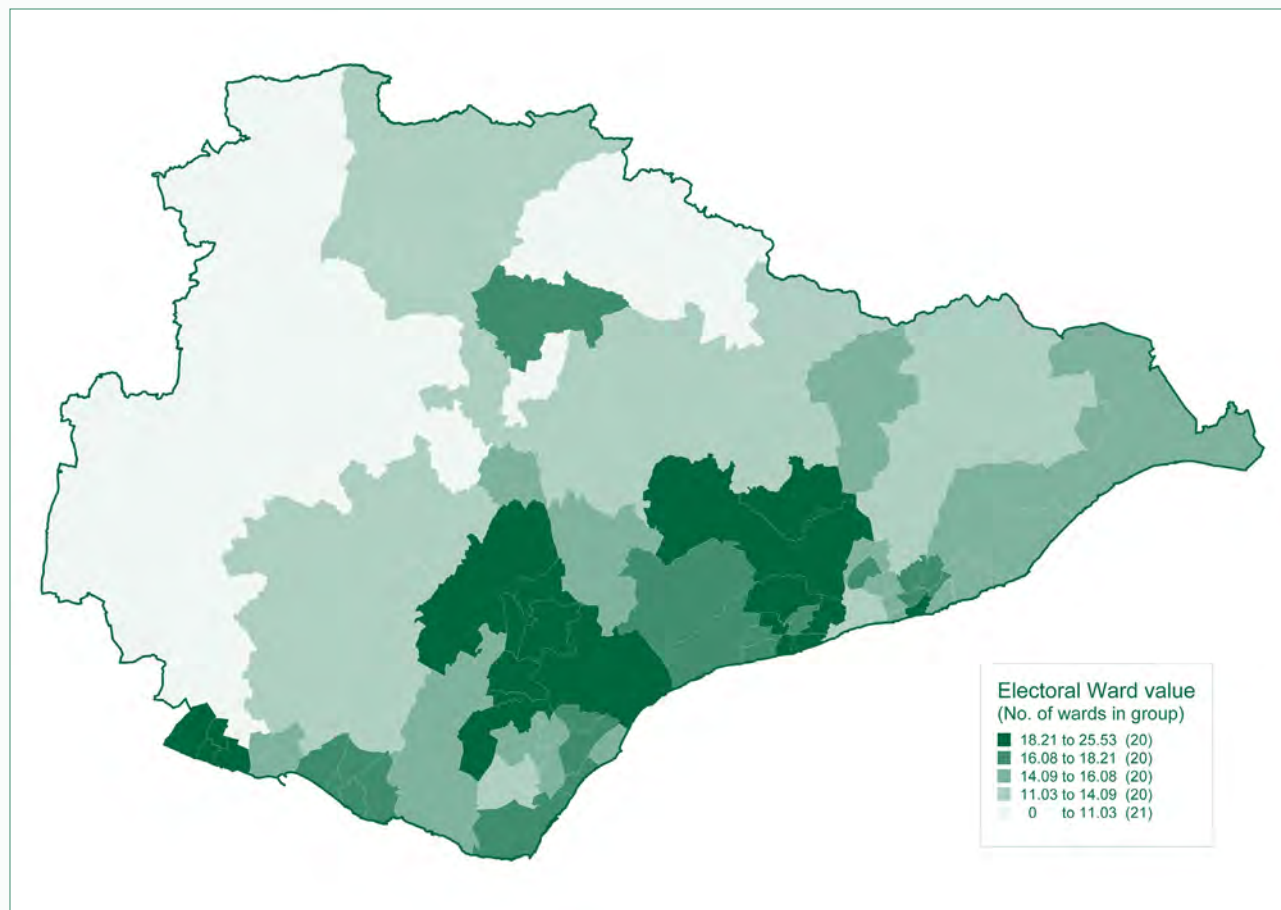
Figure 82 shows the prevalence and Figure 83 the mortality ratio for cancer, and Figure 84 the prevalence and Figure 85 the mortality ratio for COPD. Again, the maps demonstrate the difference between where those at risk of dying of cancer or COPD live and where people dying of cancer or COPD actually live.

Figure 83: *Cancer standardised mortality ratios, East Sussex electoral wards, 2003–2007*
(East Sussex = 100)



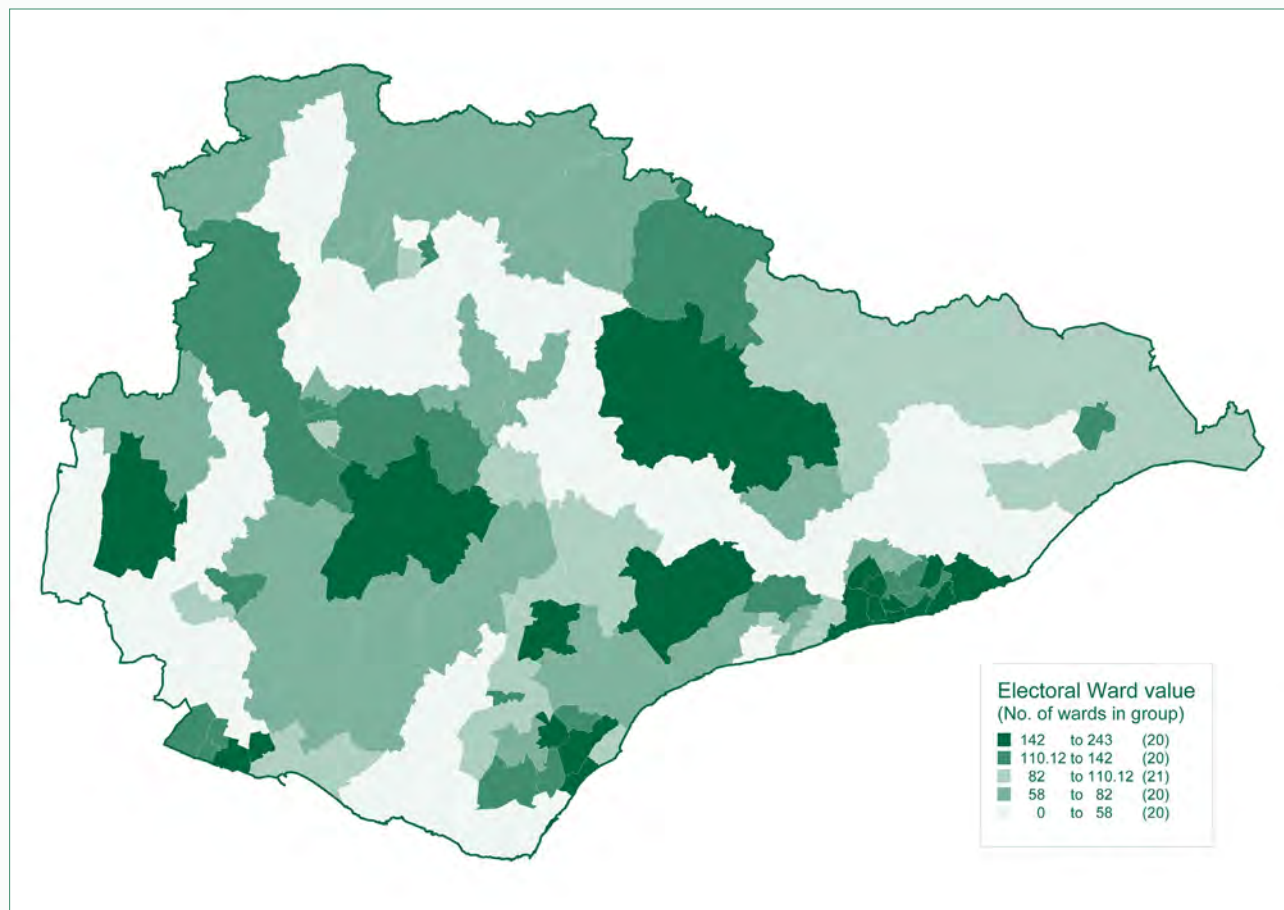
Source: ONS mortality data

Figure 84: GP reported COPD prevalence, rate per 1,000 population, GP practice data modelled to electoral wards, 2007/08



Source: QOF data

Figure 85: COPD standardised mortality ratios, East Sussex electoral wards, 2003–2007
(East Sussex = 100)



Source: ONS mortality data

We've seen from Chapter 2 that the three main contributors to the gap in life expectancy in East Sussex are circulatory diseases, cancer and respiratory diseases and we've seen from analysis of general practice recorded QOF prevalence that there is more to be done in identifying patients. Large numbers of people are not accessing the services, and thus information, medication, regular checks on key clinical symptoms, and access to support for lifestyle change.

QOF clinical management indicators

There are several QOF indicators that focus on the management of patients once they are on a disease register. We have 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. The indicators chosen were those allocated the highest number of QOF points, reflecting their importance as well as the work required to achieve them. Achievement against the following 16 indicators was analysed by deprivation quintile:

- **Atrial Fibrillation 03** – The percentage of patients with atrial fibrillation who are currently treated with anti-coagulation drug therapy or an anti-platelet therapy.
- **Asthma 6** – The percentage of patients with asthma who have had an asthma review in the previous 15 months.
- **Asthma 8** – The percentage of patients aged eight and over diagnosed as having asthma from 1 April 2006 with measures of variability or reversibility.
- **Hypertension (BP4)** – The percentage of patients with hypertension in whom there is a record of the blood pressure in the previous 9 months.
- **Hypertension (BP5)** – The percentage of patients with hypertension in whom the last blood pressure (measured in the previous 9 months) is 150/90 mmHg or less.
- **Cancer 3** – The percentage of patients with cancer, diagnosed within the previous 18 months who have a patient review recorded as occurring within 6 months of the practice receiving confirmation of the diagnosis.
- **Coronary Heart Disease 6** – The percentage of patients with CHD in whom the last blood pressure reading (measured in the previous 15 months) is 150/90 mmHg or less.
- **Coronary Heart Disease 8** – The percentage of patients with CHD whose last measured total cholesterol (measured in the previous 15 months) is 5 mmol/l or less.
- **Chronic Obstructive Pulmonary Disease 10** – The percentage of patients with COPD with a record of FEV1 in the previous 15 months.
- **Chronic Obstructive Pulmonary Disease 13** – The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the MRC dyspnoea score in the preceding 15 months.
- **Heart Failure 3** – The percentage of patients with a current diagnosis of heart failure due to left ventricular dysfunction (LVD) who are currently treated with an angiotensin converting enzyme inhibitor or angiotensin receptor blocker, who can tolerate therapy and for whom there is no contra-indication.
- **Cardiovascular Disease Primary Prevention 1** – In those patients with a new diagnosis of hypertension (excluding those with pre-existing CHD, diabetes, stroke and/or TIA) recorded between the preceding 1 April to 31 March: the percentage of patients who have had a face to face cardio-vascular risk assessment at the outset of diagnosis (within three months of the initial diagnosis) using an agreed risk assessment tool. (Only patients aged 30 to 74 years (v16)).
- **Smoking 3** – The percentage of patients with any or any combination of the following conditions: CHD, stroke or TIA, hypertension, diabetes, COPD, chronic kidney disease, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the previous 15 months. Except those who have never smoked where smoking status need only be recorded once since diagnosis.

- **Smoking 4** – The percentage of patients with any or any combination of the following conditions: CHD, stroke or TIA, hypertension, diabetes, COPD, chronic kidney disease, 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.
- **Stroke and Transient Ischaemic Attack 6** – The percentage of patients with a history of TIA or stroke in whom the last blood pressure reading (measured in the previous 15 months) is 150/90 mmHg or less.
- **Stroke and Transient Ischaemic Attack 8** – The percentage of patients with TIA or stroke whose last measured total cholesterol (measured in the previous 15 months) is 5 mmol/l or less.

Practices are able to exclude certain categories of patients from the calculation of performance (Exception Reporting); for example:

- Patients who have been recorded as refusing to attend review
- Newly diagnosed within the practice or newly registered
- Patients for whom it is not clinically appropriate; for example, those who have an allergy and other contra-indications or adverse reaction and the terminally ill
- Patients who have given informed dissent to treatment
- Patients who have not tolerated relevant medication or who are on a maximum tolerated dose of medication
- Patients who have a supervening condition that makes treatment of their condition inappropriate

Exception reporting was introduced to allow practices to pursue the quality improvement agenda and not be penalised where, for example, patients do not attend for review, or where a medication cannot be prescribed due to a contraindication or side-effect.

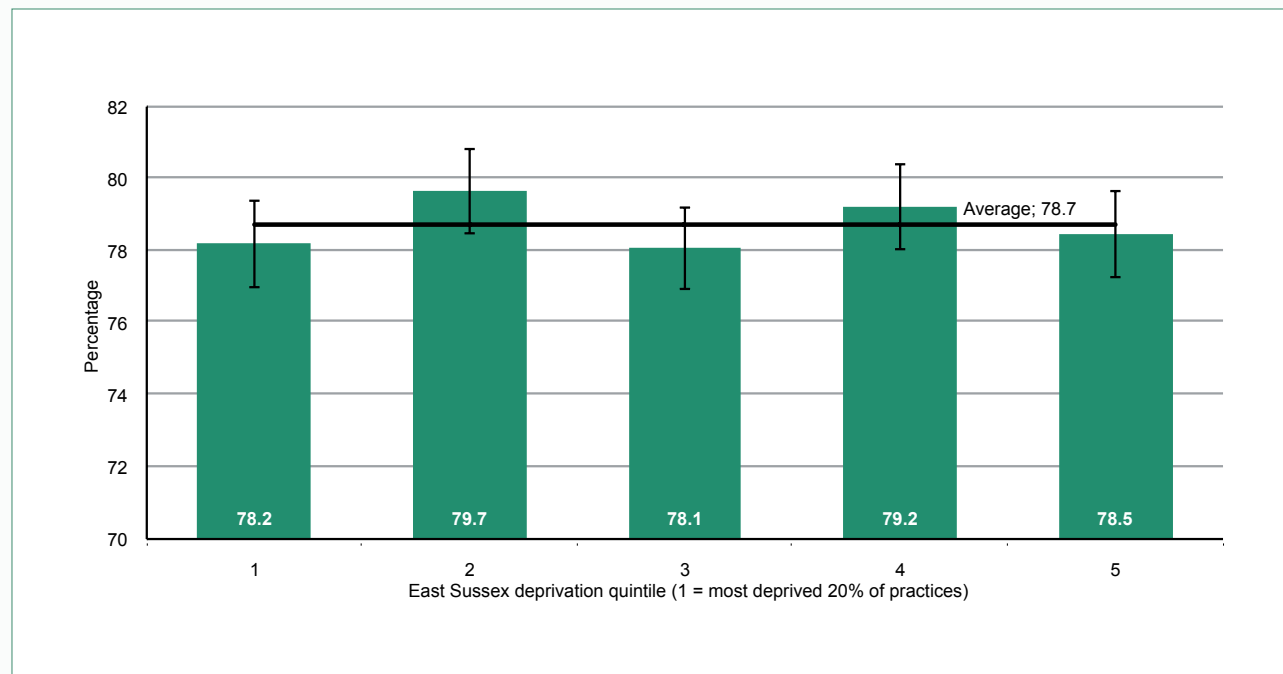
The overriding principles to follow in deciding whether to exempt a patient are that:

- The duty of care remains for all patients, irrespective of exception reporting arrangements.
- It is good practice for clinicians to review from time to time those who are excepted from treatment; i.e. to have continuing knowledge of health status and personal health goals.
- The decision to exception report must be based on clinical judgement, with clear and auditable reasons coded or entered in free text on the patient's record.
- There should be no blanket exceptions: the relevant issues with each patient should be considered by the clinician at each level of the clinical indicator set.

The PCTs provide guidance to practices on details of appropriate exception reporting for the indicators where relevant.

Analysis of achievement against QOF indicators of clinical management of patients with circulatory diseases, cancer and respiratory diseases showed no or little difference between practice performance by deprivation quintile except for two indicators, BP5 and Smoking 4. 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.

Figure 86: Achievement of QOF non-clinical indicators by deprivation quintile, East Sussex, 2009/10



Source: Quality Outcomes Framework and IMD 2007

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 (Figure 86).

We 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.

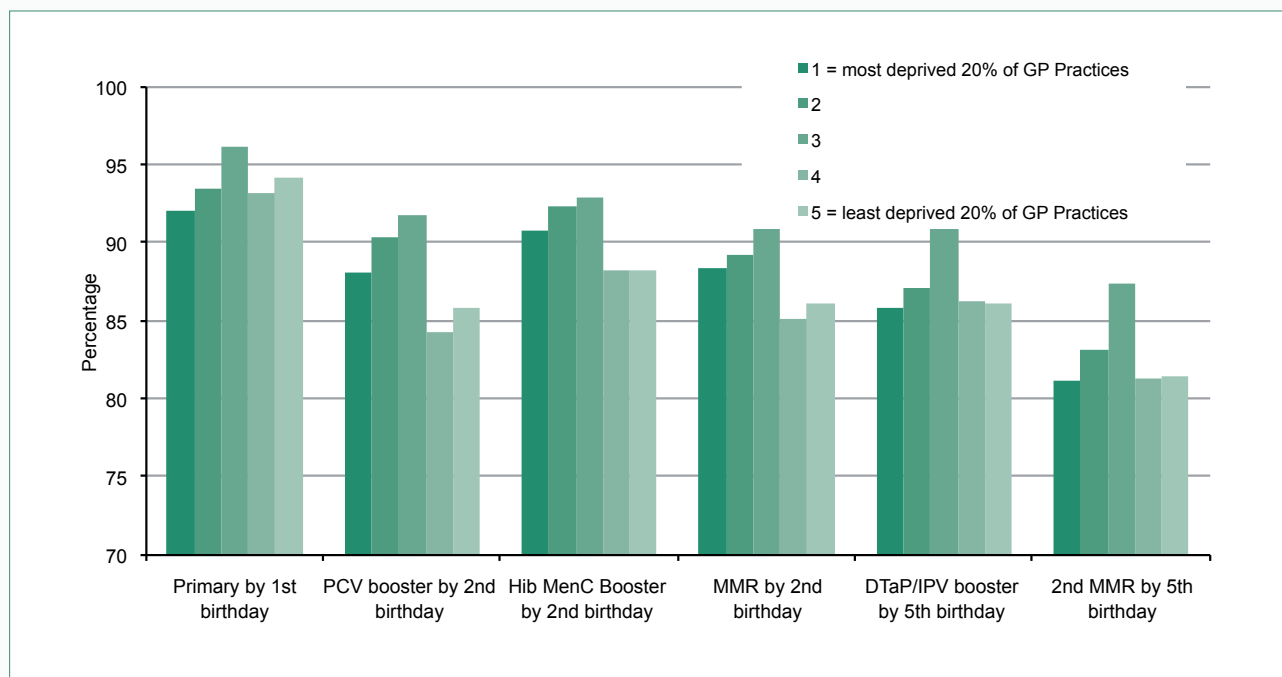
Childhood immunisations

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

Cervical screening

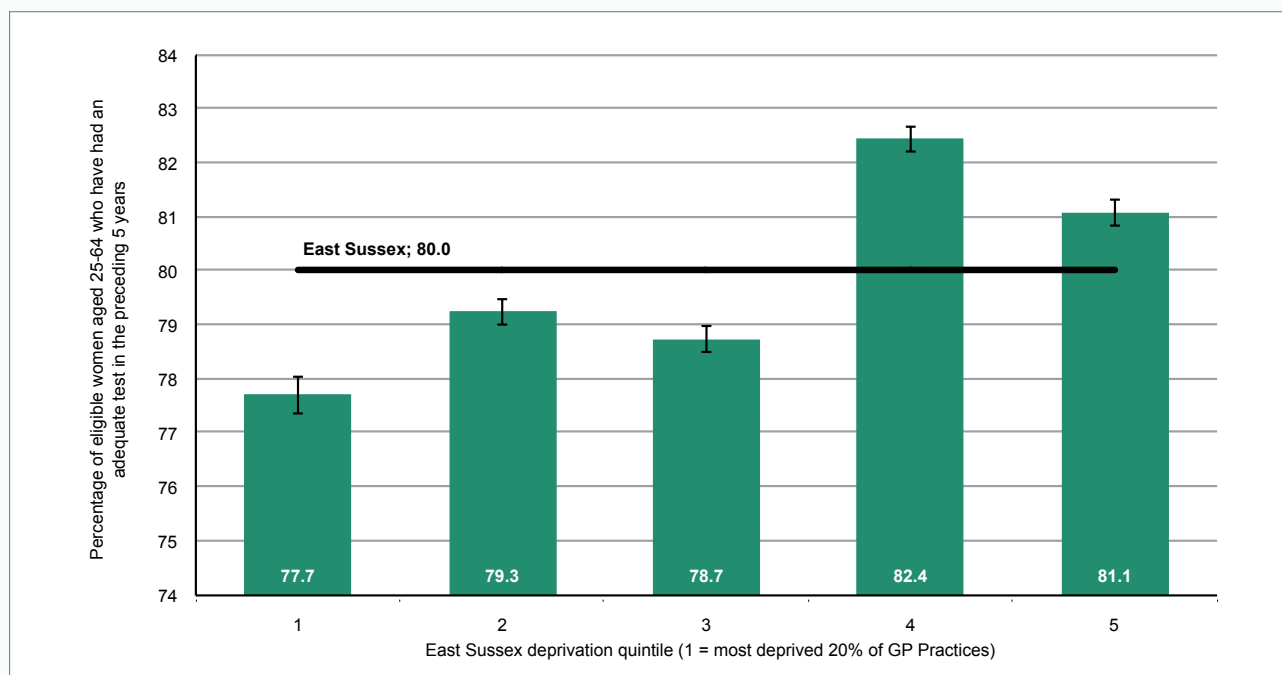
There is a clear evidence base that regular cervical screening saves lives. Figure 88 demonstrates an association between deprivation and uptake of cervical screening. The target is for at least 80% of women to have had a test in the last five years, but the figure indicates that only those GP practices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

Figure 87: Childhood immunisation coverage by deprivation quintile, East Sussex, 2009/10



Source: Child Health System and IMD 2007

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



Source: Quality Outcomes Framework 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. However, abusive or violent behaviour towards GPs and their staff is on the increase and, when this happens, patients may be asked to leave the doctor's list to ensure the safety of not only the practice staff and GPs but also of other patients.

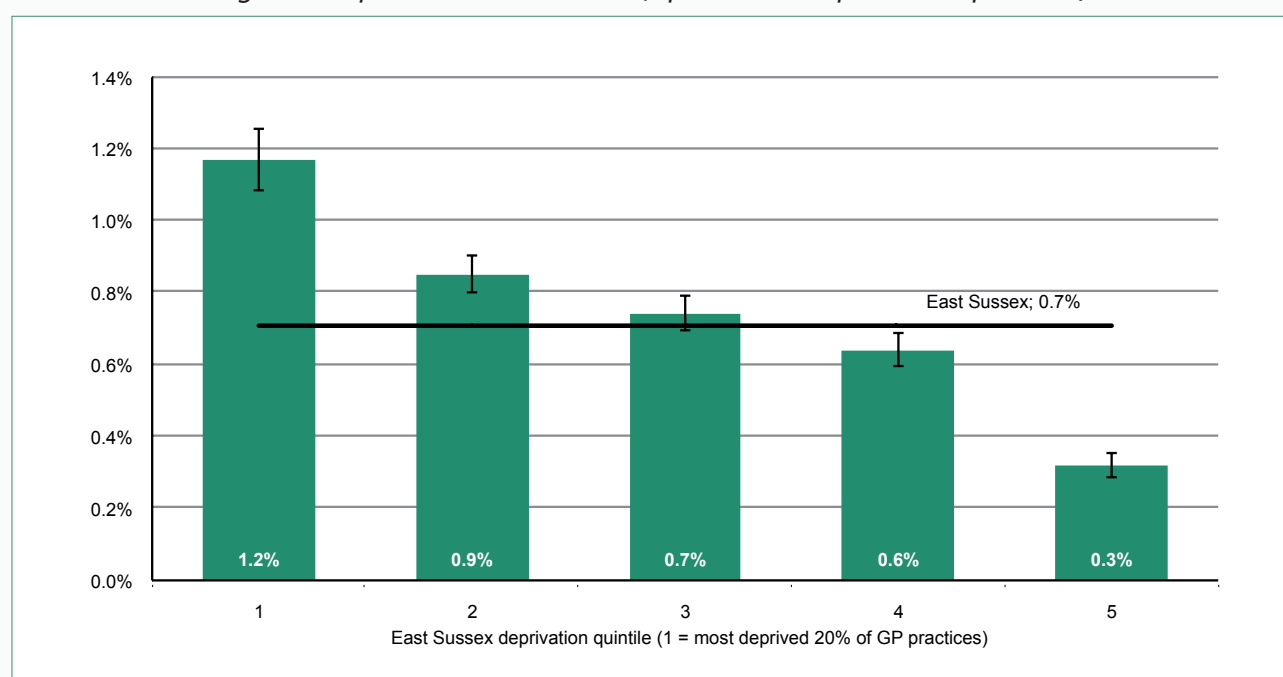
For most people, the convenience of the nearest practice is the main determinant of where they register. Nevertheless, many go further afield, and historic factors may be important in their choice. When they move, those in urban areas often remain with their original practice, and the desire to maintain a link with a doctor known to the family appears to be stronger than any wish to minimise the distance travelled to the practice premises. The availability of a woman doctor and, for patients from ethnic minorities, doctors from their own cultural group, may also be important.

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 have analysed the number of people changing practice without changing their postcode to see if this is associated with deprivation (Figure 89).

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.

Figure 89: Percentage of patients who have changed the GP practice they are registered with but have not changed their postcode of residence (April 2009 compared to April 2010)



Source: Exeter GP registrations data and IMD 2007

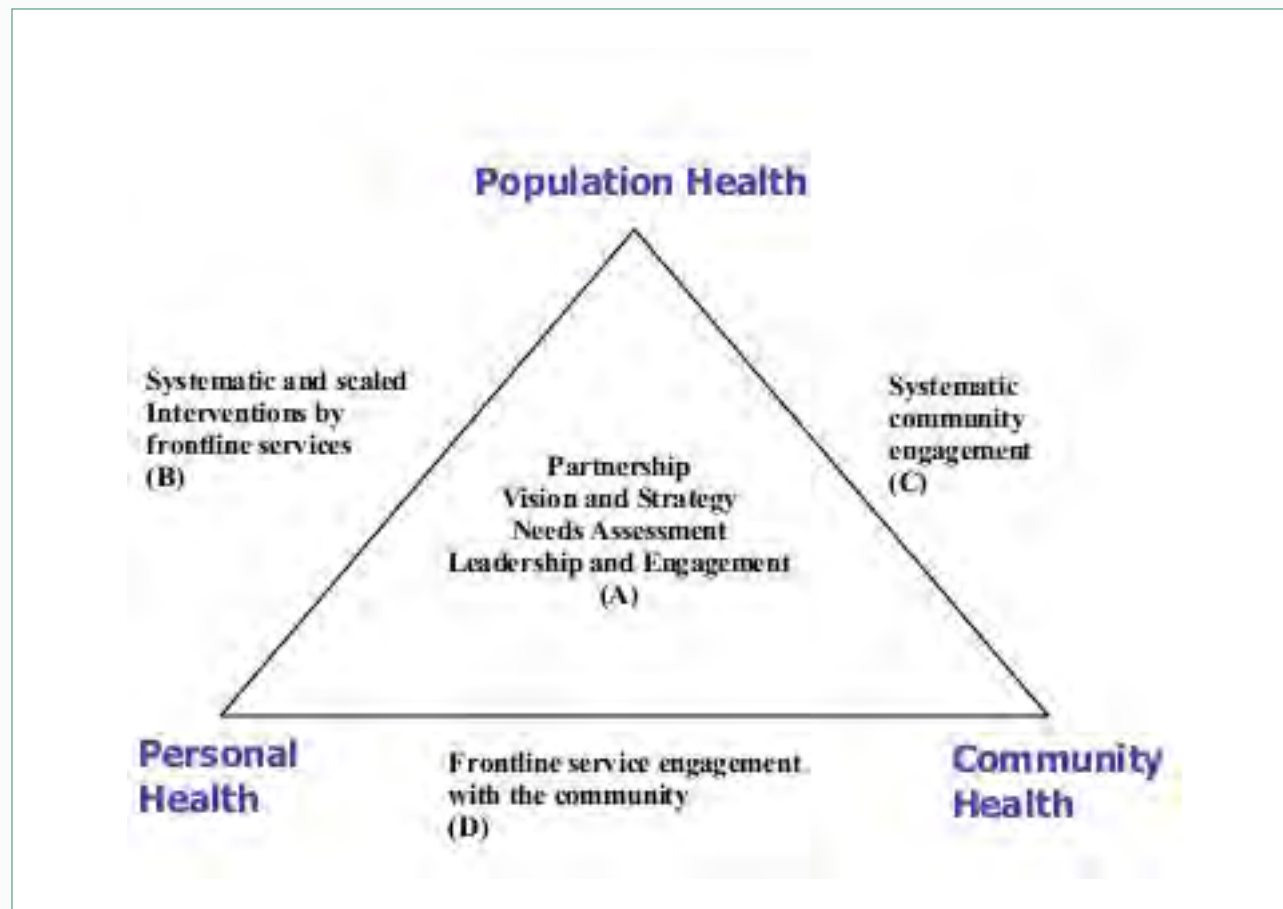
Implementing the Health Inequalities National Support Team Evidence Base

The 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; eg, register management, taking into account the necessary scale of activity and balancing 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 need 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.

Figure 90: Achieving change at population level



Hitting population-level targets

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

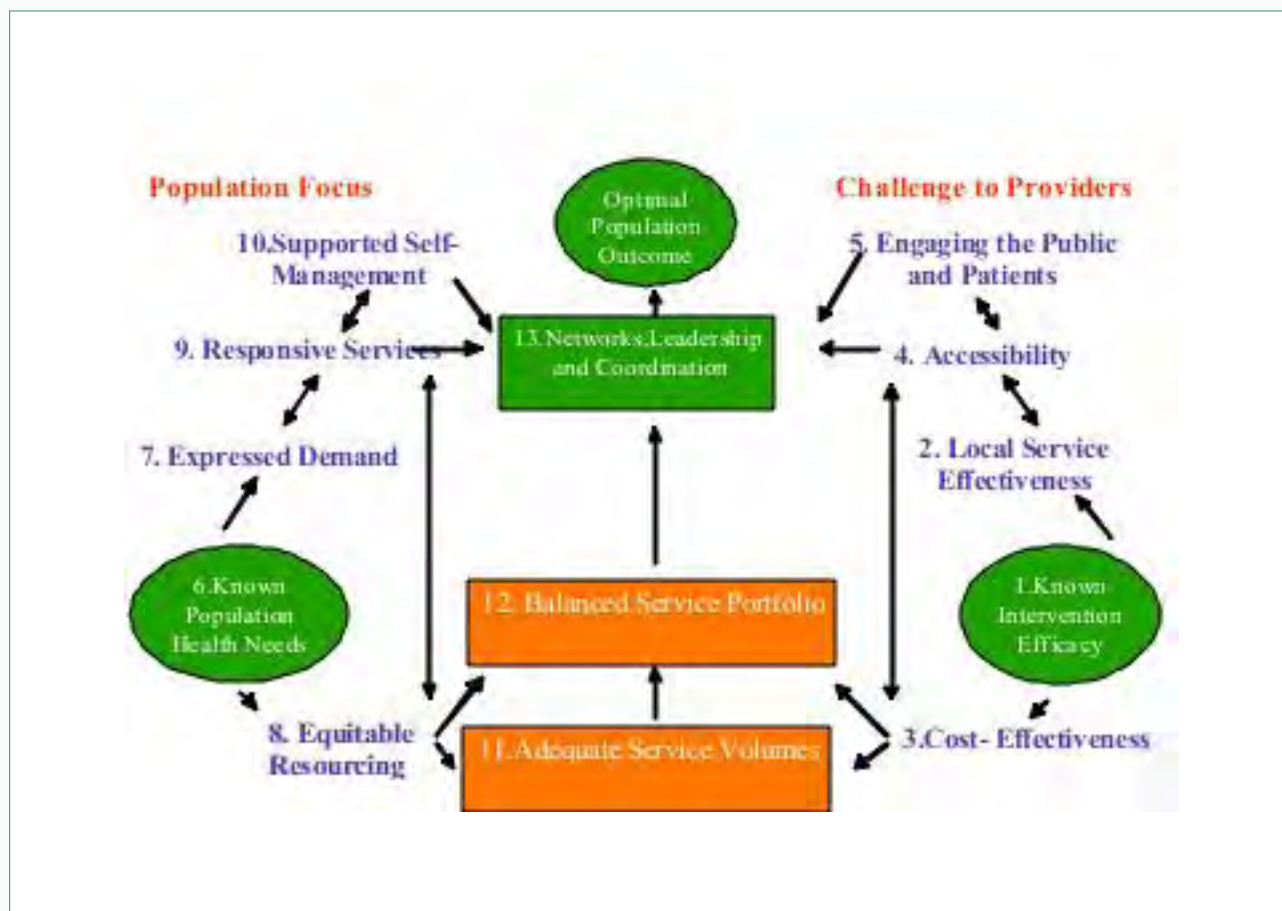
1. **Population health level**
Direct input at population level through legislation, regulation, taxation and mass media, etc (eg. preventing smoking in enclosed public spaces).
2. **Personal health level**
Applying effective personal health interventions (eg. cholesterol management with statins, affordable 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.

Reducing health inequalities through a combination of these factors will depend on ‘the organised efforts of society’ at four points in the health triangle (A, B, C, D) as shown in Figure 90.

These lessons learned by the HINST are explained more fully below:

- A. The whole must be driven by committed leadership fostering engagement, effective local strategic partnership, and a locally owned, coherent vision and strategy.
- B. Interventions must be provided effectively, with system and scale by frontline services proactively pursuing health outcomes.
- C. Community development should be addressed in a systematic way, rather than ad hoc, targeting engagement and support to the weakest and least capable of responding alone.

Figure 91: Commissioning healthcare for best outcomes



D. A range of processes should connect frontline services into the heart of communities, reaching out to ‘seldom seen, seldom heard’ groups and individuals.

Achieving impact at population level

To achieve an impact at population level, systems of delivery need to move from being project based to being programme based. The HINST has established a set of criteria by which to achieve this. Programme characteristics include:

- Evidence-based interventions where research findings and professional consensus are strongest;
- Outcomes orientated, with measurements locally relevant and locally owned;
- Systematically applied and not depending on exceptional circumstances and exceptional champions;

- Scaled up appropriately, as ‘industrial-scale’ processes require different thinking to small ‘bench experiments’;
- Appropriately resourced from core budgets rather than short bursts of project funding; and
- Persistent and continuing for the long haul, capitalising on, but not dependent on, fads, fashion and policy priorities.

The National Support Team for Health Inequalities ‘Christmas tree’ diagnostic

The HINST have developed a diagnostic model that identifies those factors which will determine whether a given intervention will achieve its best possible outcomes in a given population (Figure 91).

Figure 91 contains 13 components (numbered 1–13). Components 1, 2, 3, 4, 5 are grouped under Challenge to Providers and determine whether the services delivering the intervention will produce the optimal service outcomes. Components 6, 7, 8, 9, 10 are grouped under Population Focus and best outcomes at population level, including maximum health gain with minimal health inequalities, will not be achieved without attention to these. These factors determine how the population will use, and be supported to use, the available services. Components shown in the middle of Figure 91 (components 11, 12, 13) influence how commissioners and their providers will balance and co-ordinate need and supply.

Each of the components in the ‘Christmas Tree’ is explained below:

Challenge to providers

1. Known intervention efficacy

Services should be set up and maintained on the basis of best current knowledge of the efficacy of interventions and national guidance. If interventions are being employed to have an impact at population level, clear levels of evidence are required, avoiding interventions where there is doubt or lack of consensus.

2. Local service effectiveness

Service providers should maintain consistent high standards of local effectiveness through education and training. This should be driven by integrated systems of professional and organisational governance and audit.

3. Cost-effectiveness

If interventions are to have an impact on the whole population, it is necessary to ensure that they are delivered in the most cost-effective manner, so that the programme is affordable and sustainable.

4. Accessibility

Bringing services closer to patients and communities may substantially improve uptake, presentation and utilisation. However, service reconfiguration and commissioning initiatives need to balance this with issues around effectiveness and cost-effectiveness for optimum overall impact.

5. Engaging the public and patients

Delivery systems for interventions should be based around, and directly respond to, the needs of the person, rather than the person having to fit around the needs of the service. Patient and community inputs should be drawn in systematically.

Population focus

6. Known population health needs

It is necessary to carry out an appraisal of the main components of mortality that contribute to the mortality gap.

7. Expressed demand

Many people with important health needs fail to present with them to services or present too late. This is particularly true of those in deprived circumstances, who have many competing needs, those with chaotic lifestyles, those with personal challenges (low IQ, poor literacy, low expectation) and those from different cultures. Patients need to be identified and registered otherwise they will not benefit from interventions.

8. Equitable resourcing

There is a need to move from historical to needs-based funding. This is critical if health inequalities are to be addressed. Achieving equitable outcomes with individuals from deprived circumstances costs disproportionate amounts for delivery and support.

9. Responsive services

When patients express demand and present for services appropriately, and with resources targeted and available, services should respond actively to channel them effectively to interventions they will benefit from. The HINST has identified exceptions as being potentially a mechanism whereby the system is driving the inequalities gap wider. It currently allows many of the most complex, vulnerable and least amenable patients to be excluded from assessment of disease management. As a minimum, the HINST recommends that all PCTs develop an exceptions strategy as part of their validation.

10. **Supported self-management**

Patients can end up on a complicated array of medication, which can be challenging for anyone to manage. It may be necessary to commission interventions such as structured education programmes. Segmentation of the delivery options, rather than a one-size-fits-all approach, has proven beneficial.

Balance and co-ordination of need and supply

11. **Adequate service volumes, and**

12. **Balanced service portfolio**

Paying attention to the way the population uses services and supporting them to do so will drive up demand for services.

13. **Networks, leadership and co-ordination**

Balancing all the many complex factors that influence whether an intervention is delivered efficiently and effectively through service, and that the population is supported to access and utilise the service appropriately, requires leadership and co-ordination. This will be a major role for the commissioners, but also for networks engaging local providers.

The framework described above, outlines the practical steps that can be taken to achieve health inequalities targets, has been used successfully by the HINST.

Balanced scorecards

Implementation of a Balanced Scorecard can improve both the quality of general practice overall 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.

A Balanced Scorecard can also fulfil a range of supplementary functions including to:

- promote good quality, and support improvement in efficiency and effectiveness;
- to detect falling performance early enough to prevent adverse consequences;
- identify appropriate capacity to deliver outcomes;
- identify areas where there is need for service redesign;
- provide commissioning data/information (for commissioning primary care and integrated services);
- reassure patients in terms of the quality of service and published information, enabling patients to make robust choices about which primary care services they wish to access;
- demonstrate the value of primary care – making its role and impact visible;
- demonstrate that primary care is ‘fit for purpose’;
- unpick and improve the quality of data, which can reassure practices that they have the appropriate levels of investment; and
- support the development of an effective, local, contractual performance framework in which personal medical services (PMS) and alternative providers of medical services (APMS) contracts are in place.

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.

4 / How can we achieve more and move forward faster?

The HINST have identified some specific metrics that are of particular interest for addressing health inequalities:

Capacity and accessibility

- Number of face-to-face GP appointments per year per patient;
- Number of trained nurse appointments per year per patient;
- Extended hours offered (outside core hours);
- Patient experience (using patient surveys);
- Disability access;
- Consultation languages;
- Cultural sensitivities; and
- uptake of enhanced services to map availability and uptake by population to ensure accessibility.

Prescribing

- use of statins; and
- Ratio of angiotensin converting enzyme inhibitors to angiotensin-II antagonists >75% (excluding combination products).

Public health

- Percentages achieved for cervical screening, childhood immunisations and breast screening;
- Flu vaccine uptake;
- CHD, cancer and infant mortality; and
- All-age, all-cause mortality and life expectancy level (male and female).

Value for money

- Prescribing indicators – prescribing costs versus outcomes for diabetes and hypertension management; and
- Urgent and elective referrals per 1,000 weighted population compared across practice Super Output Areas (SOAs).

Quality and Outcomes Framework indicators

- Prevalence – actual identified against predicted;
- Exception reporting – reasons why;
- Work being done to treat those above the QOF indicators target;
- Diabetes – HbA1c achievement;
- Cardiovascular disease management – blood pressure control, treatment and distribution;
- Chronic obstructive pulmonary disease management; and
- Cancer referrals – early diagnosis, urgent versus non-urgent, 2-week referrals (and diagnosis ratio).

Local targets

- Smoking cessation – effectiveness.

Local context

- IMD 2007 score;
- Demographics: population aged over 75 years.

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 how the practice is doing relative 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 does not; and
- enable the PCT to provide different inputs to practices based on their demography.

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 those factors which 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 GP 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 GP chronic disease management audits using a z-score-based dashboard should be developed that focuses on key care pathways, such as CHD, cancer and COPD care.

The Marmot Review

The first section of this chapter has focused on quality in general practice and the HINST evidence on what will impact in a short timescale if delivered at a sufficient scale.

To influence the determinants of health requires multiagency 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 the targets on infant mortality and life expectancy.

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.
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:
 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 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 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 and the highest priority being given to the first objective to give every child the best start in life.

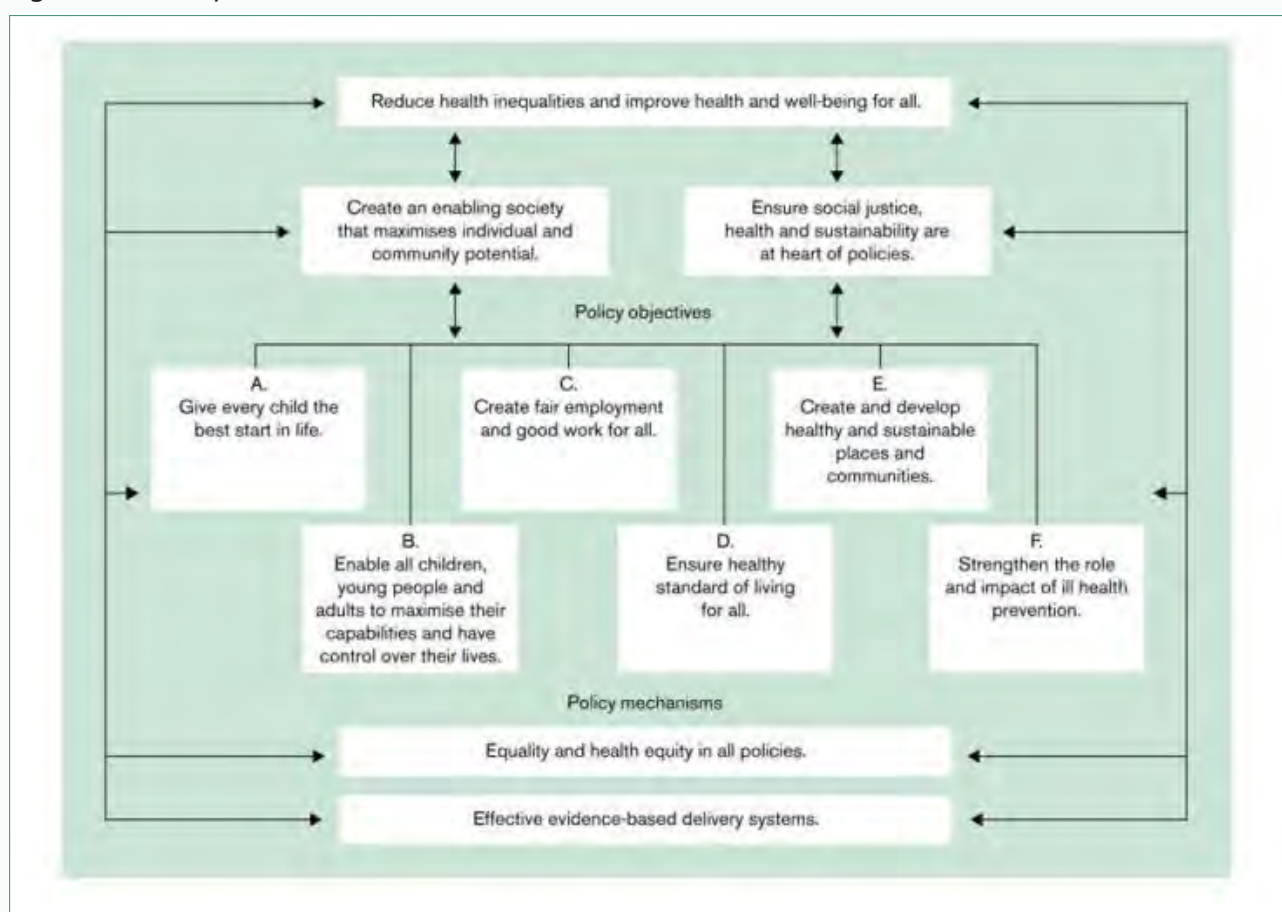
The six policy objectives are underpinned by two policy mechanisms:

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.

This conceptual framework is presented diagrammatically above.

Each of the policy objectives is supported by policy recommendations and suggested indicators to assess performance improvement in delivering review recommendations (see Appendix 1).

Figure 92: Conceptual framework for action



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:

- The imperative of greater social justice and sustainability and the implications for policies to redistribute power and resources, and improve financial systems.
- Policies to maintain and improve universal health and welfare systems.
- 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:

- Creating opportunities for individuals and communities to set the agenda for change to define local problems and search out local solutions.
- Developing, commissioning and improving good quality, integrated local services co-produced with the public to achieve better outcomes for communities and individuals.
- 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. Implementation of the Marmot Review requires a multiagency 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 (Appendix 1).

Recommendations

1. The ten major lessons learned by the Health Inequalities National Support Team 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 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 Reduction Implementation Plan needs to be developed to implement the Marmot Review and the recommendations outlined in this report.

Framework of Indicators to Assess Performance Improvement in Delivering Review Recommendations

POLICY OBJECTIVE A: GIVE EVERY CHILD THE BEST START IN LIFE					
POLICY OBJECTIVES: A1: REDUCE INEQUALITIES IN THE EARLY DEVELOPMENT OF PHYSICAL AND EMOTIONAL HEALTH, COGNITIVE, LINGUISTIC, AND SOCIAL SKILLS. A2: ENSURE HIGH QUALITY MATERNITY SERVICE, PARENTING PROGRAMMES, CHILDCARE AND EARLY YEARS, EDUCATION TO MEET NEED ACROSS THE SOCIAL GRADIENT A3: BUILD THE RESILIENCE AND WELLBEING OF YOUNG CHILDREN ACROSS THE SOCIAL GRADIENT					
POLICY RECOMMENDATIONS	DELIVERY MECHANISMS AND INTERVENTIONS	PROCESS INDICATORS	OUTPUT INDICATORS	OUTCOME INDICATORS	DELIVERY AGENCIES
A1					
Increase the proportion of overall expenditure allocated to the early years and ensure expenditure on early years development is focused progressively across the social gradient	Identify extent of spend nationally and locally and build increases into spending reviews.	Level of spend.	Growth in services and quality.	Aspirational targets for child development.	HMT, DCSF, Local authorities, local partnerships.
A2					
Support families to achieve progressive improvements in early years development, including:	See details below.	Increased number and quality of parenting programmes and increased take-up across the gradient.	Improved parenting skills and values.	Improvement in the cognitive, linguistic, emotional, behavioural and physical outcomes for children aged 2–3 across the gradient.	DCSF, DWP, local authorities, NHS, third sector, employers.

(i) Giving priority to pre and post natal interventions that reduce adverse outcomes of pregnancy and infancy	Ante natal care, home visiting.	Engagement with women at risk across the social gradient (e.g. ante natal care). More parents in receipt of quality home-visiting support across the gradient e.g. quantity, reach and quality of health visiting in year 1.	Risk reduction (e.g. smoking in pregnancy), breastfeeding rates. Parenting skills improved across the gradient	Improved birth outcomes (e.g. mother's age, gestational age, birth weight and infant death).	DH, DCSF, NHS.
(ii) Providing paid parental leave in the first year of life with a minimum income for healthy living	Include in legislation on workers entitlements	Take up of parental leave.	Child development milestones.	Improvement in the cognitive, linguistic, emotional, behavioural and physical outcomes for children aged under 2.	DWP, HMT employers.
(iii) Providing routine support to families through parenting programmes, children's centres and key workers, delivered to meet social need via outreach to families	Provide health visiting, family nurse partnerships, SureStart, child care, intensive social and behavioural interventions, community-based parenting skill programmes.	Health visiting and family nurse engagement in each early year of child's life (e.g. quantity, reach and quality measures). SureStart engagement across the social gradient.	Child development milestones.	Improvement in the cognitive, linguistic, emotional, behavioural and physical outcomes for children.	DCSF, local authorities, the third sector, private providers.
(iv) Developing programmes for the transition to school	Provision of skilled key workers across the transition for all. Targeting of those with greater social and emotional needs.	Children and parents supported across the social gradient.	Social and emotional skills at age six.	Added value of school at seven years (e.g. physical, emotional, behavioural and cognitive).	DCSF, local authorities, the third sector, private providers.

Appendix I

A3	Provide good quality early years education and childcare proportionately across the gradient. This provision should be:	Early years provision (e.g. quantity, reach and quality).	Increase in no. of children accessing quality early education and childcare across the gradient. Increased recruitment of well-qualified staff into the early years workforce, including the no. of early years settings with staff with graduate qualifications.	Development of under-three programmes to incorporate a greater level of structured play and involvement of schools with families.	Readiness for school at 5 years (e.g. physical, emotional, behavioural and cognitive).	DCSF, local authorities, the third sector, private providers.
	(i) Combined with outreach to increase the take-up by children from disadvantaged families	Provision of skilled workers to target those with greater social and emotional needs.	As above, focused on those with greatest social need.	As above, focused on those with greatest social need.	As above, focused on those with greatest social need.	DCSF, local authorities, the third sector, private providers
	(ii) Provided on the basis of evaluated models and meet quality standards	Implementing a model based on piloting, evaluation and roll-out for all new innovations	Increase in evaluated pilots and use of proven programmes.	Improved quality standards in early education.	Improved readiness for school at 5 years for those going through proven programmes.	DCSF, NHS R&D, ESRC and other research funders, local partnerships.

POLICY OBJECTIVE B: ENABLE ALL CHILDREN, YOUNG PEOPLE AND ADULTS TO MAXIMISE THEIR CAPABILITIES AND HAVE CONTROL OVER THEIR LIVES.					
POLICY OBJECTIVES: B1: REDUCE THE SOCIAL GRADIENT IN SKILLS AND QUALIFICATIONS. B2: ENSURE THAT SCHOOLS, FAMILIES AND COMMUNITIES WORK IN PARTNERSHIP TO REDUCE THE GRADIENT IN HEALTH, WELLBEING AND RESILIENCE OF CHILDREN AND YOUNG PEOPLE. B3: IMPROVE THE ACCESS AND USE OF QUALITY LIFE-LONG LEARNING ACROSS THE SOCIAL GRADIENT.					
POLICY RECOMMENDATIONS	DELIVERY MECHANISMS AND INTERVENTIONS	PROCESS INDICATORS	OUTPUT INDICATORS	OUTCOME INDICATORS	DELIVERY AGENCIES
B1					
Ensure that reducing social inequalities in pupils' educational outcomes is a sustained priority	School/community partnerships, extend full service schools, working with parents in the community. Extending provision of social, behavioural, psychiatric and other special needs support progressively across the social gradient.	Level of appropriate resources.	Reduction of within school gradients in levels of attainment. Young people studying beyond compulsory ages and in apprenticeships.	Qualifications at 16 and 24 years.	DCSF, schools, local authorities.
B2					
Prioritise reducing social inequalities in life skills by:	As detailed below.	As detailed below.	Reduction in between school gradients in values, leadership and performance (eg. OFSTED data, teacher turnover, exclusions, truancy). Reduction in within-school performance gradients	Educational attainment, social and emotional development and physical and mental health at 7, 11, 13 and 15 years. Reduction in numbers not in employment, education or training at ages under 19 and 19–21. Reduction in offending and antisocial behaviour rate	Education, social services, youth justice system, third sector, Connection, NHS CAMS, civic society and communities.

Appendix I

(i) Extending the role of schools in supporting families and communities and taking a 'whole child' approach to education	School/ community partnerships, extend full service schools, working with parents in the community, expanded remit for PSHE, extending leisure and cultural activity.	Increased proportion of schools adopting full service school approaches.	Reduction in between school gradients in values, leadership and performance (e.g. OFSTED data, teacher turnover, exclusions, truancy).	Reduction in within-school performance gradients. Reduction in numbers not in employment, education or training at ages under 19 and 19-21. Reduction in offending and antisocial behaviour rates.	DCSF, schools.
(ii) Consistent implementation of the full range of extended services in and around schools	Extend full service schools and provision of social, behavioural, psychiatric and other special needs support progressively across the social gradient.	Increased proportion of schools adopting full service school approaches and delivering programmes to prevent mental health difficulties among children and young people	Attitudinal and behavioural change. Increased opportunities (e.g. resilience, capability, volunteering).	Reduction in numbers not in employment education or training at ages under 19 and 19-21. Reduction in offending and antisocial behaviour rates	DCSF, schools, local authorities, third sector and private sector.
(iii) Developing the school based workforce to build their skills in working across school-home boundaries and addressing social and emotional development, physical and mental health and wellbeing	Appropriate training programmes (both in-service and during initial training).	Improved training and qualifications of school and family support staff to address social and emotional development, health and wellbeing within both schools and families.	Output indicators as for B2 (i) and B2 (ii).	Outcome indicators as for B2 (i) and B2 (ii).	Universities, teacher training institutions.
B3					
Increase access and use of quality lifelong learning opportunities across the social gradient, by:	Increased provision of opportunities in settings that are appropriate across the social gradient.	Increase in training and development, opening up of recruitment and progression opportunities.	Increase in people studying beyond compulsory ages and in apprenticeships. Increased numbers participating in programmes to improve other life skills.	Increase in skills across the life course (e.g. educational and vocational attainment, subjective assessments of life skills and adult education).	Secondary and further education, Social Services, Criminal Justice System, employers, third sector, communities.

(i) Providing easily accessible support and advice for 16-25-year-olds on life skills, training and employment opportunities	Appropriate settings for the provision of advice and training.	Increase in training and development uptake by young people.	Increase in young people studying beyond compulsory ages and in apprenticeships. Increased numbers participating in programmes to improve other life skills.	Reduction in numbers of young not in employment, education or training . Reduction in offending and antisocial behaviour rates.	DCSF, schools, local authorities.
(ii) Providing work-based learning for young people and those changing jobs/careers, including apprenticeships	Appropriate training programmes (both in-service and during initial training).	Increase in work experience/ apprenticeships across the social gradient.	Increase in appropriately trained workforce.	Reduction in numbers of young people not in employment, education or training.	
(iii) Increasing availability of non-vocational life-long learning across the life course	Workplace experience. Volunteering programmes. Programmes dealing with the social gradient in skills, mental health, problem drug and alcohol abuse and anti-social behaviour and offending.	Increase in uptake of work experience/apprenticeships across the social gradient. Increase in numbers accessing programmes to address skill deficits, mental health, problem drug and alcohol abuse and anti-social behaviour and offending.	Increased opportunities (e.g. resilience, capability, volunteering).	Increased community participation rates. Reduction in mental health, problem drug use, offending and antisocial behaviour rates.	

POLICY OBJECTIVE C: CREATE FAIR EMPLOYMENT AND GOOD WORK FOR ALL					
POLICY OBJECTIVES: C1: IMPROVE ACCESS TO GOOD JOBS AND REDUCE LONG-TERM UNEMPLOYMENT ACROSS THE SOCIAL GRADIENT. C2: MAKE IT EASIER FOR PEOPLE WHO ARE DISADVANTAGED IN THE LABOUR MARKET TO OBTAIN AND KEEP WORK. C3: IMPROVE QUALITY OF JOBS ACROSS THE SOCIAL GRADIENT.					
POLICY RECOMMENDATIONS	DELIVERY MECHANISMS AND INTERVENTIONS	PROCESS INDICATORS	OUTPUT INDICATORS	OUTCOME INDICATORS	DELIVERY AGENCIES
C1					
Prioritise active labour market programmes to achieve timely interventions to reduce long-term unemployment	Employment skills escalators, Fitness for Work, incentives and conditionality.	Schemes to save or create jobs or otherwise allow people to retain contact with the labour market.	Jobs saved or created. Other indicators of labour market attachment.	Reduced levels of long term unemployment. Income from employment.	DWP, HMRC, Job Centre Plus, employers, GP's, occupational health.
C2					
Encourage, incentivise and, where appropriate, enforce the implementation of measures to improve the quality of work across the social gradient by:	Promoting consistent messages from stress management guidelines, with a focus on mental health and wellbeing.	Increased access to good work (including stress management, work life balance, occupational health).	Uptake of stress counselling and relevant leadership training. Effort reward imbalance.	Psychosocial outcomes (e.g. sickness absence, stress at work, stress-control imbalances). Opportunities for progression (e.g. upward occupational mobility).	DWP, BIS, NHS, employers, unions, HSE and NICE.
(i) Ensuring public and private sector employers adhere to equality guidance and legislation	Widespread adherence to principles of equality by employers and public services.	Changes in employer attitudes to skill development, recruitment and progression. Regulatory framework.	Increase in training and development, opening up of recruitment and progression opportunities.	Equality monitoring framework indicators.	DWP, BIS, employers, unions, EHRC

(ii) Implementing guidance on stress management and the effective promotion of wellbeing and physical and mental health at work.	Promoting consistent messages from stress management guidelines, with a focus on mental health and wellbeing.	Increased use of good management practice to reduce stress at work . Coherence of stress management guidance. Improved attitudes to effort reward imbalance. Availability of stress counselling and relevant leadership training.	Increased access to good work (including stress management, work life balance, occupational health).	Employee health outcomes.	DWP, BIS, NHS, employers, unions, HSE and NICE
C3					
Develop greater security and flexibility in employment, by:	Increase in Government and employer schemes to promote flexibility. Job security (e.g. reduce involuntary part-time, temporary or contract working). Changes in benefit structures, employment subsidies, employer attitudes. Minimum wage regulations.	Security built into regulations and employment contracts. Increased number of Government and employer schemes that promote security of employment and flexibility.	Increase in numbers of employees with secure contracts and in jobs providing flexibility.	Employee health outcomes.	DWP, BIS, employers, unions
(i) Prioritising greater flexibility of retirement age	Flexibility in regulations, pension provision and employment contracts Employer-led initiatives.	Increased availability of flexible retirement packages and pre and post- retirement work.	Increased numbers flexible retirement packages and pre and post- retirement work.	Change in employment rates before and after the statutory pensionable age.	DWP, employers, unions, occupational pension providers.

(ii) Encouraging and incentivising employers to create or adapt jobs that are suitable for lone parents, carers and people with mental and physical health problems	Greater use of direct and indirect incentives. Employer-led initiatives. Early entry to employment support for those at risk of becoming unemployed (e.g. for those in insecure jobs or with physical or mental health problems).	More incentives available Increased availability of flexible work patterns for those affected (e.g. voluntary part-time, temporary or contract working, voluntary choice of retirement age, volunteering).	Increase in numbers of those affected in jobs providing flexibility.	Employee health outcomes. Reduction in the numbers of those affected in the poverty trap and other benefit-related cliff edges.	DWP, HMT, BIS, unions, employers.
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POLICY OBJECTIVE D: ENSURE HEALTHY STANDARD OF LIVING FOR ALL					
POLICY OBJECTIVES: D1: ESTABLISH A MINIMUM INCOME FOR HEALTHY LIVING FOR PEOPLE OF ALL AGES. D2: REDUCE THE SOCIAL GRADIENT IN THE STANDARD OF LIVING THROUGH PROGRESSIVE TAX AND OTHER FISCAL POLICIES. D3: REDUCE THE CLIFF EDGES FACED BY PEOPLE MOVING BETWEEN BENEFITS AND WORK.					
POLICY RECOMMENDATIONS	DELIVERY MECHANISMS AND INTERVENTIONS	PROCESS INDICATORS	OUTPUT INDICATORS	OUTCOME INDICATORS	DELIVERY AGENCIES
D1					
Develop and implement standards for a minimum income for healthy living	Implement a minimum income for healthy living across the range of household types to be reviewed bi-annually.	Minimum income for healthy living by component (e.g. life cycle stage, source of income). Changes in benefit structures, employment subsidies, employer attitudes. Minimum wage regulations.	Reduction in the numbers below the minimum income for healthy living relevant to their life cycle circumstances.	Reduction in adverse health outcomes attributable to living on low incomes.	DWP, HMT, employers, unions.
D2					
Review and implement systems of taxation, benefits, pensions and tax credits to provide a minimum income for healthy living standards and facilitate upwards pathways	Give priority to progressive tax and fiscal measures which have proportionately beneficial impact on lower income households. Ensure no new perverse incentives created. Introduce more progressive pensions, increasing with age to counter increasing levels of poverty with age.	Reduction in regressive taxes Employment, benefits system, tax credits aligned to meet minimum income for healthy living standards. Levels of benefits received and take up rates provide improved support for minimum income for healthy living.	Income ratios reduced. Reductions in numbers living below minimum income for healthy living increased security increased (e.g. reduced persistent and recurrent poverty).	Psychosocial outcomes (e.g. sickness absence, stress at work, stress-control imbalance). Opportunities for progression (e.g. upward occupational mobility).	DWP, HMT.

D3	Remove 'cliff edges' for those moving in and out of work and improve flexibility of employment	Conduct a review of systems of taxation, benefits, pensions and tax credits to achieve the reduction of 'cliff edges' faced by those taking up employment. Set tax and benefits rules to avoid creating perverse incentives and reduce cliff edges. Employer-led initiatives.	Reduced financial cliff-edge distinctions for those entering or leaving employment. Incentives to take up employment enhanced. Availability of Government and employer schemes to promote flexibility. Employer attitudes.	Fewer people affected by cliff edges (e.g. reduction in the numbers out of employment, on incapacity benefits and trapped by other benefit-related cliff edges).	Reduced levels of unemployment and economic inactivity. Reduced adverse health outcomes associated with unemployment, insecure work or attributable to living on low incomes.	DWP, HMT, employers.
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POLICY OBJECTIVE E: CREATE AND DEVELOP HEALTHY AND SUSTAINABLE PLACES AND COMMUNITIES					
POLICY OBJECTIVES: E1: DEVELOP COMMON POLICIES TO REDUCE THE SCALE AND IMPACT OF CLIMATE CHANGE AND HEALTH INEQUALITIES. E2: IMPROVE COMMUNITY CAPITAL AND REDUCE SOCIAL ISOLATION ACROSS THE SOCIAL GRADIENT.					
POLICY RECOMMENDATIONS	DELIVERY MECHANISMS AND INTERVENTIONS	PROCESS INDICATORS	OUTPUT INDICATORS	OUTCOME INDICATORS	DELIVERY AGENCIES
E1					
Prioritise policies and interventions that both reduce health inequalities and mitigate climate change, by: (i) Improving active travel across the social gradient	Removing barriers to active travel, improving safety.	Greater accessibility to active modes of travel in all areas. Improved road layouts/separation of modes of travel. Street safety initiatives.	Increase in active miles travelled/people using active modes of travel. Reduction in traffic accident rates involving active travel and in street crime and disorder.	Improved fitness levels across the social gradient. Reduction in car travel.	DfT, Home Office, CLG, local planning/transport agencies/policy-makers.
(ii) Improving good quality open and green spaces available across the social gradient	Creation of good quality open space in all areas where it is lacking.	Reduction in walking distance to quality green space. Street and park safety initiatives.	Reduced social gradients in stress, greater levels of exercise. Reduction in crime and disorder in streets and parks.	Improved fitness levels across the social gradient.	CLG, DEFRA, Home Office, local community safety partners.
(iii) Improving the food environment in local areas across the social gradient	Economic incentives. Regulation and planning. Infrastructure investment. Education and guidance.	Reduction in local concentration of fast food outlets. Improved food options in local shops.	Reduction in consumption of unhealthy food across the social gradient and increase in healthy eating.	Health benefits associated with healthy eating across the social gradient.	CLG, BIS, DEFRA, local planning/policy-makers, commercial property developers, retailers
(iv) Improving energy efficiency of housing across the social gradient	Active energy management schemes. Changes to benefit system. Regulation of utilities. Housing improvement programmes.	Affordability of fuel for those in poverty. Reduction of numbers in poorly insulated housing. Reduction in use of high energy alternatives (e.g. transport, heating, lighting).	Reduced energy usage across the social gradient.	Fuel poverty outcomes. Carbon footprints.	CLG, BIS, DEFRA, local planning, housing associations, commercial builders, property developers.

E2	Fully integrate the planning, transport, housing, environmental and health systems to address the social determinants of health in each locality	Economic incentives. Regulation and planning. Infrastructure investment. NHS estates policy. Education and guidance. Integrated transport policies.	Greater travel options. Reduction in car use. Increase in walking and cycling.	Reduction in stress associated with living in isolated and deprived neighbourhoods.	Reduced gradients in ill health associated with social isolation and adverse impacts of travel e.g. pollution, and accidents.	CLG, DEFRA, DH, DfT, CLG, BIS, local planning/transport agencies/policy-makers, NHS, local authorities, housing associations, commercial builders, property developers, transport companies, retailers.
E3	Support locally developed and evidence-based community regeneration programmes that: (i) Remove barriers to community participation and action	Support community groups with long-term funding.	Increased opportunities for participation and community activity among local residents.	Greater participation and community activity among local residents.	Improved wellbeing of local residents affected by regeneration.	CLG, NHS, local authorities, third sector.
(ii) Reduce social isolation		Support community groups with long-term funding. Ensure transport systems facilitate mobility.	Increased opportunities for participation and community activity among local residents. Integrated transport links and street safety initiatives.	Reduction in social isolation of elderly/deprived communities.	Reduced gradients in ill health associated with social isolation and area deprivation.	DfT, CLG, BIS, DEFRA, local planning/transport agencies/policy makers, housing associations, commercial builders, property developers, transport companies, retailers.

POLICY OBJECTIVE F: STRENGTHEN THE ROLE AND IMPACT OF ILL HEALTH PREVENTION					
POLICY OBJECTIVES: F1: PRIORITISE PREVENTION AND EARLY DETECTION OF THOSE CONDITIONS MOST STRONGLY RELATED TO HEALTH INEQUALITIES. F2: INCREASE AVAILABILITY OF LONG-TERM AND SUSTAINABLE FUNDING IN ILL HEALTH PREVENTION ACROSS THE SOCIAL GRADIENT.					
POLICY RECOMMENDATIONS	DELIVERY MECHANISMS AND INTERVENTIONS	PROCESS INDICATORS	OUTPUT INDICATORS	OUTCOME INDICATORS	DELIVERY AGENCIES
F1					
Prioritise investment in ill health prevention and health promotion across government departments to reduce the social gradient.	Ensure that effort and resources in lifestyle and behavioural interventions are focused on having a progressive impact on the social gradient.	Access to advice on healthy living that is appropriate across the social gradient. Take up of preventive services across the social gradient, including early diagnosis and treatment.	Improvement in healthy living indicators across the social gradient. Increased numbers actively involved in specific disease prevention programmes across the social gradient.	Improved disease specific outcomes (incidence, prevalence, mortality).	NHS, Social Care, local authority planning, CLG, DH, third sector, retailers, food manufacturers, Food Standards, tobacco, alcohol, pharmaceutical industries.
F2					
Implement evidence-based programmes of ill-health preventive interventions that are effective across the social gradient by:	Greater emphasis on evidence based prevention in NICE programme.	Increased availability of advice on cost effective preventive interventions. Greater use of cost effective preventive interventions	Greater effectiveness of preventive programmes.	Reduction in preventable and avoidable death and disability.	NICE, NHS
(i) Increasing and improving the scale and quality of drug treatment programmes, diverting problem drug users from the criminal justice system	Medicalisation of the response to problem drug usage.	Availability of active recruitment programmes. Diversion from the criminal justice system.	Reduction in the numbers involved in problem drug use and in criminal activity to fund their usage.	Reduction in adverse health outcomes of problem drug use and the social and economic cost of drug-related crime.	NHS, MoJ, HO, ACPO, third sector

(ii) Focusing public health interventions such as smoking cessation programmes and alcohol reduction on reducing the social gradient	Refocusing of needs assessment. Development of evidence based interventions that are effective across the social gradient.	Increase in scale and intensity of evidence based preventive interventions that are effective across the social gradient.	Increased numbers actively involved in specific disease prevention programmes across the social gradient. Reduction in numbers of people across the social gradient involved in behaviours that have adverse health consequences.	Reduction in preventable and avoidable death and disability across the social gradient.	DH, NHS, local authorities
(iii) Improving programmes to address the causes of obesity across the social gradient	Refocusing of needs assessment. Development of evidence based interventions that are effective across the social gradient.	Increase in scale and intensity of evidence based preventive and health promotion interventions that are effective across the social gradient.	Reduction in the obesogenic environment and behaviours leading to obesity. Increase in aspects of healthy living that reduce obesity.	Reduction in levels of obesity and diseases associated with obesity across the social gradient	DH, NHS, local authorities
F3					
Focus core efforts of public health departments on interventions related to the social determinants of health proportionately across the gradient	Refocusing of needs assessment.	Increase in plans, guidance and advice on preventive interventions across the social gradient. Increased scale and intensity of interventions focused on the social gradient.	Increased numbers of people across the social gradient benefiting from interventions.	Reduction in preventable and avoidable death and disability across the social gradient	DH, NHS, local authorities

Glossary

Confidence intervals	A measure of how precisely a value is measured. A 95% confidence interval (as used in this report) means that there is a 95% chance that the true value lies somewhere between the higher and lower numbers given. Confidence intervals which show a wide range suggest a low degree of precision, often associated with small numbers of cases. Such values should be interpreted with caution.
Directly age standardised rates	Age-specific rates in the population we are interested in (e.g. East Sussex) are applied to a standard population; normally the European standard population is used. This produces a rate for East Sussex that would have occurred if the county had the standard population age structure. This method allows mortality / morbidity rates to be compared across different populations and time, as long as the same standard population is used.
Infant mortality rate	The infant mortality rate measures the number of deaths to babies under one year per 1,000 live births in an area.
Life expectancy	Life expectancy at birth is the average number of years a person would live if he or she experienced the age-specific mortality rates of the given area and time period for the rest of their life.
Lower Super Output Area	Super Output Areas are a geographic hierarchy designed to improve the reporting of small area statistics. Unlike electoral wards, the SOA layers are of consistent size across the country and will not be subjected to regular boundary change. LSOAs have a minimum population of 1,000 and each roughly contains 1,550 residents.
Office for National Statistics rural/urban classifications	The classification of LSOAs is built up from a lower Output Area geography. Output Areas have been classified as urban 10k where the majority of the population in the Output Area falls inside an urban area with a population of 10,000 or more. All other Output Areas are treated as rural. The methodology for the remaining rural Output Areas was constructed from an underlying settlement classification based on hectare squares (100m x 100m). For each hectare square a series of densities are calculated for addresses in a given hectare square and the surrounding squares. Every hectare square is then associated with particular settlement type: dispersed dwellings, hamlet, village, small town, urban fringe and urban.
Prevalence	Prevalence (in the context of QOF) is the number of patients with a particular condition expressed as a percentage of the practice list size. (Definition from the Information Centre QoF glossary).
Standardised mortality ratios	Indirectly age-standardised. Age-specific rates of a standard population (e.g. East Sussex) are applied to the population we are interested in (e.g. electoral ward) to calculate the expected number of events, i.e. the number of events expected in an electoral ward if they experienced the same age-specific rates as East Sussex. The expected number of events is compared to the number of events observed in the population of interest and expressed as a ratio (observed / expected). A ratio above 100 indicates a higher than expected number of events and a ratio below 100 shows a lower than expected number of events. Indirectly age-standardised rates allow comparison to the standard population only, they cannot be compared across different geographies.

Abbreviations

A&E	Accident and Emergency
AAACM	All age all cause mortality
AF	Atrial fibrillation
APHO	Association of Public Health Observatories
APMS	Alternative providers of medical services
BME	Black and minority ethnic groups
BMI	Body mass index
CHD	Coronary heart disease
CI	Confidence Intervals
COPD	Chronic obstructive pulmonary disease
CQUIN	Commissioning for Quality and Innovation
CVD	Cardiovascular disease
CYPT	Children and Young People's Trust
ESCHS	East Sussex Community Health Services
ESHT	East Sussex Hospitals Trust
GUM	Genito-urinary medicine
HARTH	Hastings and Rother Treatment for Hearts
HCCS	Hailsham Community Cardiology Services
HCP	Healthy Child Programme
HINST	Health Inequalities National Support Team
HSE	Health Survey for England
IMD 2007	Index of Multiple Deprivation 2007
JSNA	Joint Strategic Needs Assessment
LAA	Local Area Agreement
LHO	London Health Observatory
LSOA	Lower Super Output Area
LSP	Local Strategic Partnership
NAEDI	National Cancer Awareness and Early Diagnosis Initiative
NICE	National Institute for Health and Clinical Excellence
ONS	Office of National Statistics
PID	Pelvic inflammatory disease
PMS	Personal Medical Services
QOF	Quality and Outcomes Framework
SHN	Sussex Heart Network
SII	Slope Index of Inequality
SOA	Super Output Areas
STI	Sexually transmitted infection
TIA	Transient ischaemic attack

Further Information

Index of Multiple Deprivation 2007	National data and definitions: http://webarchive.nationalarchives.gov.uk/20100410180038/http://communities.gov.uk/communities/neighbourhoodrenewal/deprivation/deprivation07/ http://www.communities.gov.uk/publications/communities/indicesdeprivation07?view=Standard (summary only) Local data and further information: http://www.eastsussexinfigures.org.uk Type in a postcode or area and find out how deprived it is: http://tinyurl.com/35tsvox
Office for National Statistics rural/urban classifications	National data and definitions: http://www.ons.gov.uk/about-statistics/geography/products/area-classifications/rural-urban-definition-and-la-classification/index.html Local data and further information: http://www.eastsussexinfigures.org.uk
The London Health Observatory Health Intervention Tool	http://www.lho.org.uk/LHO_Topics/Analytic_Tools/HealthInequalitiesInterventionToolkit.aspx
South East England Health Inequalities Gap Measurement Tool	http://www.sepho.org.uk/viewResource.aspx?id=10965

