APPENDIX 4 - Pharmaceutical Needs Assessment 2025 - Equalities Impact Assessment

Health Needs and Issues of Identified Patient Groups

This appendix outlines national evidence and research into the health needs and issues of specific groups, focussing on those with Equality Act 2010 Protected Characteristics. In addition to outlining differences in health needs, any specific research on the impact for pharmaceutical services have been noted. This has been used to inform the PNA process.

Health Needs – Protected Characteristics

Age

- Adults aged 65 years and older currently represent 23% of the West Sussex population[1], suggesting a significant period of ill-health or disability may be experienced later in life.

Note: Causes of mortality by age are discussed under the Sex heading.

Long-term health conditions, multimorbidity and palliative care

- Ageing populations and longer life expectancy have resulted in an increase in long-term health conditions[2], with ageing known to be amongst the most important, and unmodifiable, risk factors for most chronic diseases, including arthritis, heart disease, cancer, diabetes, COPD, asthma, and dementia[3].
- A whole population study of more than 60 million people which aimed to determine the prevalence of multiple long-term conditions in England in 2020 found that age was the dominant predictor of multimorbidity. Overall, 29.3% had at least one long-term condition, ranging from 6.6% among those aged 0-19 years and 82.9% among those aged 80+. The prevalence of three long-term conditions was 17.1% among 60–69-year-olds, 30.8% among 70–79-year-olds and 52.5% among those aged 80+. In contrast, only 0.2% of 0–19-year-olds had three long-term conditions[4].
- It has been estimated that an additional 9.1 million people in England will be living with major illness by 2040, an increase of 2.5 million people compared to 2019. 80% of the projected increase will affect people aged 70 and over[5].
- The increasing number of individuals diagnosed with a long-term condition may have an impact on pharmaceutical services as long-term conditions often

[1] Office for National Statistics (2024). 2023 Mid-year population estimates.
[2] EUPATI (2022). Risk factors in health and disease.
[3] Niccoli & Partridge (2012). Ageing as a Risk Factor for Disease; MacNee et al. (2014). Ageing and the border between health and disease; Dhingra & Vasan (2012). Age as a risk factor
[4] Valabhji et al. (2023). Prevalence of multiple long-term conditions (multimorbidity) in England: a whole populations study of over 60 million people
[5] The Health Foundation (2023). Health in 2040: projected patterns of illness in England.

require drug therapy to achieve the best clinical outcomes and health-related quality of life[6].

- The likelihood of falls increases with age and may lead to physical injury, loss of confidence and independence and social isolation. Around a third of people aged 65 years and over will experience at least one fall a year, increasing to 50% of those aged 80 years and over[7].
- As the prevalence of chronic (and multiple) illness increases with the ageing population, the need for palliative care is likely to increase; based on 2014 estimates of existing palliative care need, one study projected between a 25% and 42% rise in the number of people needing palliative care by 2040[8]. Individuals with palliative care needs may require symptomatic relief with medicines and therefore may engage with pharmacists frequently. A small scoping review suggests that including pharmacists in palliative care teams can improve the quality of care for palliative care patients[9].

Dementia

- The risk of dementia rises significantly with age, although some people will develop early onset dementia, before age 65. In West Sussex, 16,650 people were estimated to have dementia in 2020 (500 of whom were under 65) and this figure is expected to rise to more than 22,000 people by 2030. Nearly half of these people are expected to experience 'moderate' or 'severe' dementia and may require more support and long-term care[10].
- Around 70% of people with dementia are also expected to have a comorbidity, such as high blood pressure, heart disease, diabetes and depression; the ability to manage these other conditions may be affected by the severity of their dementia, which may itself lead to poorer health outcomes, such as emergency admissions to hospital and accelerated disease progression[11].
- Pharmacy may be a touchpoint for people who are ageing and can help identify people with dementia and support both them and their carers[12]. In Wessex, a dementia friendly framework for community pharmacies was developed in 2017/18. 70% of pharmacies engaged with the scheme, with pharmacy staff

[6] Unni (2023). Medicine Use in Chronic Diseases. Pharmacy, 11(3). DOI: 10.3390/pharmacy11030100
[7] NHS UK (2022). Falls.
[8] Etkind et al. (2017). How many people will need palliative care in 2040? Past trends, future projections and implications for services.
[9] Thrimawithana et al. (2024). The role of pharmacist in community palliative care – a scoping review. Int J Pharm Pract. 32(3): 194-200. DOI: 10.1093/ijpp/riae015
[10] West Sussex County Council (2020). West Sussex Joint Dementia Strategy (2020 - 2023).
[11] APPG on Dementia (2016). Dementia rarely travels alone: Living with dementia and other conditions
[12] Community Pharmacy Hampshire and Isle of Wight. Dementia Friendly Pharmacies

commenting that the framework increased awareness of how to better support people with dementia[13]

Mental health

- In West Sussex, the prevalence of common mental health disorders is generally lower in people aged 65 and over (9.3%) compared to the overall population (14.4%)[14] indeed, the increasing prevalence of poor mental health in young people is a nationally recognised problem and discussed elsewhere in this chapter.
- In older people, however, depression (the most common mental health disorder in older people) and other mental health conditions may be underdiagnosed and undertreated[15]. This may be due to barriers to older people accessing support, including:
    - lack of recognition/awareness of symptoms of mental health problems,
    - perceptions of poor mental health as an inevitable part of ageing,
    - concerns around being a 'burden', and test
    - perceptions of stigma around mental health[16].
- The prevalence of mental health problems is not uniform across the older adult population; 40% of care home residents are affected by depression, 30% of older carers may have depression, and the likelihood of depression is four times higher in older people who have been bereaved than those who have not17.
- Pharmacy can play a key role in supporting people with mental health problems. For example, pharmacists can identify early or new signs of mental health problems and signpost to potential sources of support. Some medicines used to treat mental health problems are associated with health risks. As experts in medicines and their use, pharmacists can support the best use of medicines for patients with mental health problems, reducing adverse events, minimising avoidable harm and unplanned admissions to hospital18 19.

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[13] Moores & Rutter (2020). The Wessex Dementia Friendly Pharmacy Framework. Int J Pharm Pract. 29(2):134-136: DOI: 10.1093/ijpp/riaa001

[14] (OHID 2022). Common Mental Health Disorders.

[15] Public Health England (2019). Mental health and wellbeing: JSNA toolkit.

[16] Age UK (2019). Policy Position Paper: Mental Health (England).

[17] Age UK (2019). Policy Position Paper: Mental Health (England).

[18] Royal Pharmaceutical Society (2022). The role of pharmacy in mental health and wellbeing. The role of pharmacy in mental health and wellbeing | RPS

[19] Royal Pharmaceutical Society (2018). No health without mental health: How can pharmacy support people with mental health problems?

Social isolation and loneliness

- Social isolation and loneliness are risk factors for poorer mental and physical health, with older people being particularly vulnerable to these (nearly half of all people over 75 years live alone)[20]. Loneliness, anxiety and stress may result from social isolation, whilst social engagement may protect against cognitive decline and dementia and can promote other healthy behaviours, including physical activity and healthy eating[21]. Interaction with a pharmacist during a medication review or prescription renewal may be useful way to identify lonely individuals in need of assistance. Visiting a pharmacy may also be an important social connection for some patients[22].

Digital inclusion

- The increasing digitisation of services may adversely affect the ability of older people to access services, owing to not having access to digital devices and poor digital literacy. Non-English language speakers may also struggle with information or applications on digital platforms not being made available in other languages[23].

Older people (aged 65+) living in residential care

- Currently within West Sussex, an estimated 8,000 older people live in a care home. It is anticipated that this will increase to around 12,500 over the next 20 years[24]. In Worthing in 2021 the number aged 65 years and over living in a care home was 47 per 1,000 of the usual resident population in that age group, the highest number across local authorities in England and Wales. Worthing also had the fifth highest number of care home residents aged 85 years and over (165 per 100,000)[25].
- Many people living in care homes will have complex needs, including severe frailty, higher fall rates than in older people living in their own homes and dementia (around 70% of people living in care home have dementia)[26]
- Some services provided by pharmacies are targeted to improve the health outcomes of specific age groups. These include: influenza vaccinations for

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[20] Public Health England (2019). Mental health and wellbeing: JSNA toolkit.
[21] British Medical Association (2016). Growing older in the UK A series of expert-authored briefing papers on ageing and health.
[22] British Columbia Pharmacy Association. Social Isolation and Loneliness: a look at pharmacy's role in this public health dilemma.
[23] NHS Race and Health Observatory (2022). Ethnic Inequalities in Healthcare: A Rapid Evidence Review.
[24] Projecting Older People Population Information (2022).
[25] Office for National Statistics (2023). Older people living in care homes in 2021 and changes since 2011.
[26] Barker et al. (2020). Changes in health and functioning of care home residents over two decades: what can we learn from population-based studies?; NHS England (2023). The framework for enhanced health in care homes; Alzheimer's Society (2022). Facts for the media about dementia.

younger and older age groups (children aged 2-3 years, school-aged children from Reception up to Year 11, and those who are aged 50 years old,) and more vulnerable groups (such as those with certain health conditions, who live with an immunocompromised person, are in long-stay residential care, receive a carer's allowance/are the main carer for an older or disabled person, are a frontline health or social care worker, or are pregnant).
- NHS Health Checks, for people aged 40-74 years old.

Disability

- Disability is defined in the Equality Act 2010 as a physical or mental impairment that has a substantial and long-term adverse effect on the person's ability to carry out normal day-to-day activities. 'Substantial' is defined as the impairment being more than minor or trivial (e.g., if daily tasks like getting dressed take much longer than usual) and 'long-term' refers to a period lasting 12 months or more.
- The range of impairments that may come under this definition is broad; NHS recording codes list eleven categories of impairment type[27]:
    - Behaviour and Emotional
    - Hearing
    - Sight
    - Manual Dexterity
    - Memory or ability to concentrate, learn or understand (Learning Disability)
    - Mobility and Gross Motor
    - Perception of Physical Danger
    - Personal, Self-Care and Continence
    - Progressive Conditions and Physical Health (such as HIV, cancer, multiple sclerosis, fits)
    - Speech
    - Other.
- Although information relating to the health outcomes of people with learning disabilities is often addressed separately, data for people with other disabilities is usually aggregated. That this generalised data may hide a more nuanced picture of health for people with different types and severities of disability should be borne in mind.

Prevalence

- According to the national Family Resources Survey, in 2022 to 2023 an estimated 24% of people in the UK have a disability, with most age bands having

[27] NHS Digital (2022). Data quality of protected characteristics and other vulnerable groups.

a higher proportion of females reporting disabilities than males[28]. By age, the most commonly reported disabilities were:

    - Children – social or behavioural impairment (50%), learning impairment (32%) and mental health impairment (30%)
    - Working age adults – mental health impairment (47%), mobility impairment (41%), stamina, breathing or fatigue impairment (34%)
    - State pension age adults – mobility impairment (69%), stamina, breathing or fatigue impairment (46%) and dexterity impairment (33%)
- The 2021 census found that 16% of West Sussex residents were disabled, similar to, but slightly lower than, England overall (17.7%). There was some variation in the prevalence of disability at district and borough level within West Sussex, with prevalence highest in Arun (19.7%), Adur (19.5%) and Worthing (19.1%) and lowest in Mid Sussex (14.5%), Crawley and Horsham (14.9%)29

Overall health and wellbeing

- People with physical or mental impairments may experience poorer health outcomes than the general population and may face greater exposure to risk factors that drive inequalities in health, such as unemployment (around 50% of disabled people are in employment in the UK, compared to over 80% of non-disabled people[30]), deprivation, isolation and loneliness, and reduced access to services, including health services.
- *Wellbeing* – working age disabled adults (aged 16-64 years) report lower scores on wellbeing measures of life satisfaction, happiness and anxiety than non-disabled people, with particularly poor scores for anxiety[31].
- *Loneliness* – self-reported loneliness is more than four times higher in disabled people than non-disabled people; this figure has risen in recent years[32].
- *Mental health* – disabled children and adults both report poorer mental health than their non-disabled peers[33].
- *Comorbidities*
    - People with disabilities may experience more than one long-term condition, particularly as they age. Sight loss, for example, has significant overlaps with other conditions such as diabetes, stroke and dementia[34].

[28] Department for Work and Pensions (2024). Family Resources Survey: financial year 2022 to 2023.
[29] Office for National Statistics (2023). Disability by age, sex and deprivation, England and Wales: Census 2021
[30] Office for National Statistics (2021). Outcomes for disabled people in the UK: 2021.
[31] Office for National Statistics (2021). Outcomes for disabled people in the UK: 2021.
[32] Office for National Statistics (2021). Outcomes for disabled people in the UK: 2021.
[33] Equality and Human Rights Commission (2016). Being disabled in Britain: A journey less equal.
[34] West Sussex County Council (2022). Visual Impairment in Adults Needs Assessment.

- Disabilities themselves may also represent risk factors for other health issues. For example, disabled children and adults are more likely to be overweight or obese compared to their non-disabled peers, with greater levels of overweight/obesity reported in those with hearing, stamina/breathing/fatigue and mobility impairments[35].

Note: comorbidities are discussed further under the Age heading.

Access to services

- Access to services may vary depending on the type of disability, but common barriers may include inaccessible physical environments, including low space, lack of ramps and support equipment/fittings etc. Physical disability has been shown to be associated with greater 'unmet healthcare need', due to difficulties getting to GP surgeries and getting inside GP surgeries, with this being an increasing problem in older patients aged 65-84 years[36].
- Transport, long waiting lists and costs have also been identified as key barriers to accessing healthcare for disabled people, with female disabled people reporting worse outcomes than male disabled people. Unmet need for mental health care due to cost, for example, has been found to be more than four times higher in people with a severe disability, whilst unmet need due to the cost of prescribed medicine has been found to be more than three times higher in people with a mild disability[37].
- Other barriers to access include:
    - limited knowledge and understanding in healthcare providers of the health (and access) needs of disabled people;
    - complicated or 'jargon'-filled health information; and
    - limited communication tools, including availability of interpreters and written materials (e.g., in Braille or large print)[38].

People with learning disabilities – health outcomes

- In West Sussex in 2023/24, there were 5,690 people with learning disabilities recorded on GP registers, representing 0.6% of all people registered with GPs in the county[39].
- People with learning disabilities are at particular risk of poor health outcomes and have shorter life expectancies than the general population. The 2022

[35] Equality and Human Rights Commission (2016). Being disabled in Britain: A journey less equal.
[36] Popplewell et al. (2014). How do adults with physical disability experience primary care? A nationwide cross-sectional survey of access among patients in England.
[37] Sakellariou and Rotarou (2017). Access to healthcare for men and women with disabilities in the UK: secondary analysis of cross-sectional data.
[38] World Health Organisation (2022). Disability and health.
[39] Department of Health and Social Care (2025). Learning Disability Profiles.

Learning from Lives and Deaths – people with a learning disability and autistic people (LeDeR) report found that people with a learning disability have a shorter life expectancy than the general public with around 6 in 10 people dying before the age of 65 compared to 1 in 10 people from the general population. In addition, 42% of all deaths of people with a learning disability were seen as avoidable compared to 22% from the general population[40].

- An analysis comparing healthcare records of adults with learning disabilities to the general population found differences in disease burden[41]. Adults with learning disabilities had:
    - Higher recorded levels of comorbidities, with levels of epilepsy and severe mental illness particularly high, alongside increased levels of dementia, dysphagia and vision and hearing impairments (amongst others). Levels of cancer and CHD were lower in adults with learning disabilities, although this is likely related to the lower life expectancy in these people.
    - Higher mortality rates, particularly in adults with Downs syndrome, with rates of deaths classed as being amenable to healthcare intervention almost six times greater than the general population (an inquiry into premature deaths of people with learning disabilities found 42% of deaths between 2010 and 2012 were premature, with the most frequent reasons being delays or problems with diagnosis/treatment and issues with identifying needs and providing appropriate care[42]).
    - More emergency hospital admissions, with more than a third of these deemed preventable (compared to 17% in the general population). Epilepsy, lower respiratory tract infections and urinary tract infections were the most common preventable reasons for admission.
    - A greater likelihood of being prescribed a psychotropic drug (three times more than controls) and receiving repeat medication (nearly twice as likely as controls).

People with learning disabilities – access to healthcare

- The above discussed analysis of healthcare records of adults with learning disabilities also found concerning differences in use and access to care; adults with learning disabilities made greater use of primary care consultation than the general population but were more likely to have shorter appointments (less than

[40] White, A; Sheehan, R; Ding, J; Roberts, C; Magill, N; Keagan-Bull, R; Carter, B; Chauhan, U; Tuffrey-Wijne, I; Strydom, A; (2023). Learning from Lives and Deaths - People with a learning disability and autistic people (LeDeR) report for 2022.
[41] Carey et al. (2017). An evaluation of the effectiveness of annual health checks and quality of health care for adults with intellectual disability: an observational study using a primary care database.
[42] Heslop et al. (2013). Confidential Inquiry into premature deaths of people with learning disabilities.

10 minutes) with low continuity of care with the same doctor. The inquiry into premature deaths of people with learning disabilities between 2010 and 2012 similarly identified lack of coordinated care across services and disease pathways for these people[43].

- As people with learning disabilities have poorer health outcomes, annual health checks are available for all people aged 14 and over, however not everyone is eligible receives one; between April 2024 and January 2025, 61.12% of patients on the learning disability register received a health check[44].
- People with learning disabilities may also be limited in accessing healthcare or health information due to:
    - communication difficulties, including difficulties in asking for help, explaining health problems, asking questions, extra time needed to process information, needing information to be presented in different formats and retaining verbal information, coupled with lack of reasonable adjustments by health services for this;
    - reliance on others (e.g., family carers or support workers) and consequently not being well informed themselves, which may be a greater issue if there is a high turnover of support staff, or inadequate information given to carers (studies have found high numbers of people with learning disabilities not fully understanding why they were taking medicines or they and their carers not receiving adequate/any information from the pharmacy);
        - low expectations;
        - poor understanding of mental capacity; and
        - not identifying connections between new/worsening symptoms (e.g., gaining weight) and medications that they are taking[45].
- Pharmacy has a role to play in supporting people with learning disabilities. For example, people with learning disabilities may need more help to understand what a medicine is for and how it is supposed to help, how and when to use it and any side effects. They may also need additional time to understand information and may require information in different forms (e.g. practical demonstrations, easy read leaflets using pictures and simple works or video clips)[46].

[43] Heslop et al. (2013). Confidential Inquiry into premature deaths of people with learning disabilities.
[44] NHS England (2025). Learning Disabilities Health Check Scheme, England, January 2025.
[45] Public Health England (2017). Pharmacy and people with learning disabilities: making reasonable adjustments to services.
[46] Public Health England (2017). Pharmacy and people with learning disabilities: making reasonable adjustments to services.

Race

- In the 2021 Census, 15.8% of the West Sussex population identified as a minority ethnic group, this is lower than in the South East (21.2%) and England (26.5%). Several recent reviews show that there are marked differences in health issues and behaviours across ethnic groups.
- In terms of overall health, people from some ethnic minority groups are more likely to report being in poorer health, including having limiting long-term illnesses, and poorer experiences of using health services compared to the white population[47]. Racial discrimination may play a part in this, with a recent review finding poorer mental and physical health in adults of minority ethnicities who perceive racial discrimination than in those who do not[48].
- However, minority ethnic groups do not uniformly fare worse in health outcomes; as shown in the selected following examples, risk factors and disease prevalence vary across ethnic groups, with different groups experiencing a greater burden of different diseases.

Life expectancy and causes of death

- Analyses from ONS show a lower life expectancy and higher all-cause mortality rate in the White ethnic group compared to any other ethnic group, except the Mixed ethnicity group[49].
- In contrast, disability-free life expectancy is estimated to be lower among several minority ethnic groups than the White population[50].
- Mortality rates from individual causes of death vary across ethnic groups, although mortality rates for cancer and dementia and Alzheimer's disease, are highest among White ethnic groups[51]
- *Diabetes:* Compared to White groups, South Asians have up to a sixfold greater risk of developing diabetes and Black groups a threefold higher prevalence. Diabetes develops at the younger age in these ethnic groups[52].
- *Cardiovascular disease (CVD):* heart disease is one of the most common causes of death for all ethnic groups, although South Asian groups experience some of the highest rates and mortality from circulatory diseases, including stroke and heart disease (and the latter has been found to develop at a younger age than

[47] Kings Fund (2021). The health of people from ethnic minority groups in England.
[48] Hackett et al. (2020). Racial discrimination and health: a prospective study of ethnic minorities in the United Kingdom.
[49] Office for National Statistics (2021). Ethnic differences in life expectancy and mortality from selected causes in England and Wales: 2011 to 2014. NB: the disproportionate impact of the COVID-19 pandemic on those of minority ethnicities, including higher rates of infection and mortality, has resulted in higher overall mortality in some ethnic minority groups compared to the white population.
[50] The Kings Fund (2023). The health of people from ethnic minority groups in England.
[51] The King's Fund (2023). The health of people from ethnic minority groups in England.
[52] The King's Fund (2023). The health of people from ethnic minority groups in England.

other groups). In contrast, Black groups have a lower risk of heart disease compared to most other groups yet experience high rates and mortality from hypertension and stroke, with the latter happening at a younger age[53].

- *Cancer:* Cancer mortality overall is lower among minority ethnic groups compared to white groups. However, among Bangladeshi males, lung cancer mortality is higher, and among Black males, prostate cancer mortality is higher[54].
- *Suicide:* Mortality rates for suicide in males are highest in White and Mixed ethnicity groups and in the Mixed ethnicity group in females[55].
- *Covid-19:* The Covid-19 had a disproportionate impact on ethnic minority groups. They had higher infection and mortality rates than the white population, although ethnic differences in Covid-19 mortality declined over the course of the pandemic[56].
- *Infant and maternal mortality*
- In 2018-2020, maternal mortality was 3.7 times higher in Black ethnic groups and 1.7 times higher in Asian ethnic groups compared in White groups (although overall numbers are low: fewer than 10 a year for both Black and Asian ethnic groups)[57].
- Although stillbirth and infant mortality rates have decreased for all ethnic groups in recent years, differences remain, with the highest rates in Black and Pakistani ethnicity babies[58].

Mental health

- Experiencing a common mental health problem is more likely among Black (23%), Asian (18%) and Mixed (20%) groups compared to white groups (17%), however these groups are less likely to receive support for their mental health[59]. Black adults are the least likely to receive treatment for their mental health (6% compared to 13% of White British adults)[60].
- A greater number of people of Black African and Caribbean ethnicities come into contact with mental health services via the criminal justice system, rather than via their GP or referral to talking therapies, than people of white ethnicities[61].

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[53] The King's Fund (2023). The health of people from ethnic minority groups in England.
[54] The King's Fund (2023). The health of people from ethnic minority groups in England.
[55] Office for National Statistics (2021). Ethnic differences in life expectancy and mortality from selected causes in England and Wales: 2011 to 2014.
[56] The King's Fund (2023). The health of people from ethnic minority groups in England.
[57] The King's Fund (2023). The health of people from ethnic minority groups in England.
[58] The King's Fund (2023). The health of people from ethnic minority groups in England.
[59] NHS Digital (2016). Mental Health and Wellbeing in England, Adult Psychiatric Mortbidity Survey 2014 England.
[60] NHS Digital (2016). Mental Health and Wellbeing in England, Adult Psychiatric Mortbidity Survey 2014 England.
[61] Final report of the Independent Review of the Mental Health Act 1983.

- Black Caribbean people are also more likely to be referred to specialist mental health services by their GP, rather than be treated in primary care, and are more likely to be detained under the Mental Health Act[62].

Risk factors and the wider determinants of health[63]

- *Protective and risk factors for health:* these vary amongst ethnic groups, with groups often exhibiting a mix of behaviours. White groups, for example, tend to have a higher prevalence of smoking and harmful alcohol use than most minority ethnic groups, whilst also having a higher proportion of people eating the recommended portions of fruit or vegetables per day. Obesity is more prevalent in Black ethnic groups compared with White groups (and lower in other minority ethnic groups), and Black and Asian children experience higher rates of childhood obesity. Along with Asian groups, Black groups are also more likely to report being physically inactive.
- Some differences in health by ethnicity may be attributable in part to different cultural practices; as cultures assimilate, this health gap may lessen. Cancer rates in South Asian groups, for example, may be becoming more alike to those of White ethnicities.
- *Deprivation*: Risk factors for poorer health tend to cluster in more deprived communities, in which ethnic minority groups are over-represented (minority ethnic groups comprise 22% of people in deprived areas yet only 15% of the total population).

Religion or belief

- Religious views and beliefs may influence health, such as in:
    - attitudes towards contraception, unwanted pregnancies and abortion, reproductive medicine and neonatal care;
    - the types of treatments, medicines and vaccines able to be used (e.g., ingredients in some medicines and vaccines may be forbidden in some religions);
    - the effect of fasting on those with long-term conditions or those breastfeeding;
    - spiritual interpretations of diseases and possible stigma attached to health problems, such as mental health conditions; and
    - the impact on mental health of religious prohibitions of some sexual orientations and gender reassignment[64].

[62] Bhui et al. (2018). Making a difference: ethnic inequality and severe mental illness.
[63] The Kings Fund (2023). The health of people from ethnic minority groups in England.
[64] Department of Health (2009). Religion or belief: A practical guide for the NHS.

Sex

- Sex plays a significant role in health and disease outcomes, with differences observed in life expectancy, causes of mortality and prevalence of lifestyle risk factors.
- Some differences are attributable to biological and genetic factors, such as the prevalence, clinical presentation and response to treatment (including differing pharmacokinetics and pharmacodynamics) of various diseases. Other differences may be the result of gender and the social environment, such as behavioural/lifestyle differences affecting risk exposure[65].
- Importantly, a significant female health gap has been identified in the UK, with research showing that women tend to experience poorer care and health outcomes than men. In addition to biological sex differences that affect health and response to treatments, a recent national survey collecting women's views identified barriers to good health, including:
    - not feeling listened to by healthcare professionals, including experiences of problems not being taken seriously, having to self-advocate to receive a diagnosis (often over long periods of time), limited opportunities to ask questions about treatment after a diagnosis and treatment preferences being ignored;
    - poor access to information on women's health topics, such as menstrual wellbeing, gynaecological cancers and conditions, and the menopause; and
    - inconvenient locations and timings for access to services[66].

Attitudes to health and perceptions of services

- Attitudes towards health and illness also play a part in differential use of services, with men being less likely than women to visit a pharmacy or GP and at risk of delaying seeking healthcare (although women have also been found to often underestimate their risk of cardiovascular disease and seek treatment for heart attacks later than men[67]). Discomfort in the pharmacy environment may play a part in avoiding behaviour in men, which may be due to perceptions that pharmacies are for older people or are feminine environments, and that they lack privacy[68].
- Embarrassment or discomfort may able be a barrier to access in women in some cases; a recent review of young women's views and experiences of emergency

[65] Mauvais-Jarvis et al. (2020). Sex and gender: modifiers of health, disease, and medicine.
[66] Department of Health and Social Care (2022). Results of the 'Women's Health - Let's talk about it survey'.
[67] Mauvais-Jarvis et al. (2020). Sex and gender: modifiers of health, disease, and medicine.
[68] Pharmacy Consumer Research (2009). Pharmacy usage and communications mapping.

hormonal contraception (EHC) provided by community pharmacies, for example, found concerns around not wanting to be overheard, being embarrassed at having to 'confess' needing EHC and perceptions of possible judgemental attitudes from pharmacists[69].

Life expectancy and disability-free life expectancy

- Women can expect to live longer than men on average, although women will tend to spend more of their lives living with disability or in poorer health than men. In West Sussex, female life expectancy is 4.2 years longer than males (84.6 years in females compared to 80.4 years in males)[70] but disability-free life expectancy in females is only 61.5 years, compared to 65 years in males[71].

Causes of mortality

- Data on the top ten causes of death by sex are available from the Global Burden of Disease (GBD) study (most recently updated in 2021) and reported at local West Sussex level[72]:
- Men and women share the same top three causes of death, which are cancers, cardiovascular diseases and respiratory infections and TB, although ONS analyses of causes of death show different burdens of these diseases by sex at different ages. In 2015, cancers killed more women aged 35-49 than men and more men in those aged 50-79. Heart disease and strokes killed nearly double the number of men than women aged 50-79[73].
- Men and women differ in the fourth top cause of death in the GBD study, with chronic respiratory diseases (such as chronic obstructive pulmonary disease (COPD) and other lung conditions) for men and neurological disorders (such as dementia, epilepsy, motor neurone disease, and multiple sclerosis) for women. The greater burden of neurological diseases in women likely reflects the longer life expectancy of women compared to men, although there is evidence that women have a greater risk of dementia and Alzheimer's Disease than men, even when age-corrected[74].
- The tenth biggest cause of death for each sex in the GBD was not included in the other sex's top ten; self-harm and interpersonal violence was the tenth most common cause of death in men (three-quarters of all self-harm and interpersonal violence deaths were in males), whilst musculoskeletal disorders

[69] Chirewa and Wakhisi (2019). Emergency hormonal contraceptive service provision via community pharmacies in the UK: a systematic review of pharmacists' and young women's views, perspectives and experiences.

[70] Public Health Outcomes Framework. Data from 2021-2023(OHID).

[71] Public Health Outcomes Framework. Data from 2018-2020 (OHID).

[72] Global Burden of Disease in West Sussex (2019).

[73] Office for National Statistics (2016). Does our sex affect what we die from?

[74] Office for National Statistics (2016). Does our sex affect what we die from?

was the tenth most common cause in women (three-quarters of all deaths from musculoskeletal disorders were in women).

- In people aged 5-49 years, ONS analyses also show that external causes, including accidents and suicides, are the leading cause of death and more common in men than women. In 2015, male deaths from external causes were more than three times as common than female deaths from external causes, with 80% of the deaths that were recorded as suicides being in males[75]. More recent figures show that between August 2023 and October 2024, males accounted for 74.4% of all deaths by suspected suicide[76].

Lifestyle factors

- Population surveys generally find a greater number of men self-reporting risky health behaviours compared to women, although women tend to have lower physical activity levels than men (particularly pronounced in Black, Asian and Other ethnicities)[77]
- *Smoking* – the Annual Population Survey (2023) found that more men smoked than women (13.4% vs. 9.9%), a pattern which has been consistent since 2011
- *Alcohol* – the 2022 Health Survey for England found that women were more likely to report not drinking in the last week or drinking at a lower risk level for alcohol-related harm (14 or fewer units a week) compared to men. Drinking at increasing or higher risk was more common in men[78].
- *Obesity/diet* – although obesity levels are high in both sexes, the 2022 Health Survey for England found being overweight or obese to be more common in men (69% vs. 59%)[79].

Mental health

- Women and girls are more likely than men to experience common mental health disorders[80] and eating disorders[81] and prevalence of these is increasing. This is a particular issue in younger women and is apparent before adulthood; at age 17, 22% of females in the Millennium Cohort Study had high levels of psychological distress, including symptoms of depression and anxiety (as did 10% of males). This study also found greater proportions of females reporting self-harming (28% of 17 year olds) and increasing numbers of males self-harming (increasing form

[75] Office for National Statistics (2016). Does our sex affect what we die from?
[76] Office for Health Improvement & Disparities (2025). Statistical report: near to real-time suspected suicide surveillance (nRTSSS) for England for the 15 months to October 2024.
[77] The Kings Fund (2023). The health of people from ethnic minority groups in England.
[78] NHS England (2024). Health Survey for England, 2022 Part 1. Adult drinking.
[79] NHS England (2024). Health Survey for England, 2022 Part 1. Overweight and obesity in adults.
[80] NHS Digital (2016). Adult Psychiatric Morbidity Survey, 2014.
[81] NHS Digital (2020). Health Survey for England 2019.

9% at age 14 to 20% at age 17)[82]. The rate of hospital admissions for mental health conditions for females in West Sussex under 18 is more than double the rate of males (86.2 per 100,000 vs. 38.1 per 100,000)[83].

Pregnancy and Maternity

- There are several common conditions that may occur in pregnancy, for which pharmaceutical and non- pharmaceutical (e.g., lifestyle and dietary changes) interventions may be recommended. These include nausea and vomiting, heartburn, pelvic pain, symptomatic vaginal discharge and vaginal bleeding. Some pregnant people may also be at risk of venous thromboembolism, gestational diabetes, pre-eclampsia and hypertension[84].
- Mental and physical health issues may also emerge in the post-natal period, the former including depression and anxiety disorders, severe mental illness and sleeping problems, and the latter including post-natal bleeding, and bladder and bowel function. Other health issues depend on the type of birth, such as wound healing and infection risk in caesarean births[85].
- Some commissioned services specifically address the needs of pregnant women, such as smoking cessation programmes aimed at reducing the number of women who smoke during pregnancy.
- Some medicines, including commonly taken painkillers such as ibuprofen and aspirin, are not recommended during pregnancy as they can cross the placenta and reach the baby. Pharmacists can advise on whether it is safe to take a prescribed medicine, or a medicine that is purchased at a pharmacy or shop without a prescription, during pregnancy[86].

Sexual Orientation and Gender Reassignment

The following section summarises issues relating to these protected characteristics. We have grouped these together as a number of key evidence sources are the same, for example surveys conducted in relation to LGBT young people. Wherever possible we present the findings in relation to the specific protected characteristic.

- For clarification definitions in the Equality Act 2010 are as follows:
    - Sexual Orientation means a person's sexual orientation towards (a) persons of the same sex, (b) persons of the opposite sex, or (c) persons of either sex.

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[82] Millennium Cohort Study (2020). High levels of serious mental health difficulties among 17-year-olds..
[83] Department of Health and Social Care. Fingertips: Hopsital Conditions for Mental Health Conditions (<18 yrs).
[84] National Institute for Health and Care Excellence (2021). Antenatal Care. NICE guideline NG201.
[85] National Institute for Health and Care Excellence (2021). Postnatal care. NICE guideline NG 194.
[86] NHS (2022). Medicines in pregnancy.

- Gender re-assignment - A person has the protected characteristic of gender reassignment if the person is proposing to undergo, is undergoing or has undergone a process (or part of a process) for the purpose of reassigning the person's sex by changing physiological or other attributes of sex.
- Lesbian, gay, bisexual and transgender (LGBT) people report being less satisfied with their life than the overall population[87]. Studies have found that the prevalence of mental health problems is significantly higher in LGBT people than the general UK population, although evidence is lacking around the physical health outcomes of LGBT people[88] This is compounded by poor experiences and discrimination, experienced and anticipated, in health services.

Mental health

- A YouGov survey of around 5,300 LGBT people, undertaken on behalf of the Stonewall charity, found high levels of depression, anxiety, self-harm, suicide, addiction and eating disorders in these groups. These appear to be compounded by the intersection of other characteristics, with LGBT people who are also of black or minority ethnicities, disabled or living in lower income households often reporting worse outcomes, in addition to younger LGBT and non-binary people[89]:
- *Depression and anxiety* – Half of all LGBT respondents experienced depression in the last year and three-fifths experienced anxiety. The self-reported prevalence of these was highest in trans people, and younger (aged 18-24 years), black or minority ethnicity, and lower income LGBT people.
- *Self-harm* – LGBT groups reporting the highest levels of self-harm were 18–24-year-olds (48%), non-binary people (41%), trans people (35%) and disabled people (28%).
- *Suicide* – Around half of non-binary, trans and LGBT people aged 18-24 years reported that they thought about suicide in the last year (compared to 31% of non-trans LGB people).
- *Addiction* – one in ten LGBT reported experiencing some form of addiction in last year, rising to 19% in LGBT people who are disabled.
- *Eating disorders* – 12% of respondents experienced an eating disorder in last year. This was higher in non-binary, black or minority ethnicity and trans LGBT people (ranging from around a fifth to a quarter in these groups).

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[87] Government Equalities Office (2018). National LGBT Survey.
[88] National Institute of Economic and Social Research (2016). Inequality among lesbian, gay bisexual and transgender groups in the UK: a review of evidence.
[89] Stonewall (2018). LGBT in Britain: Health Report.

- In relation to trans people, one study reported some evidence of a 'pathologisation' of mental health, whereby mental health problems are attributed to the person's gender identity[90].

Health behaviours

- Use of alcohol, drugs and smoking varies with age, with younger LGBT people reporting greater use of drugs and smoke, whilst older LGBT people report more alcohol consumption. According to the YouGov/Stonewall survey [91]
- 15% LGBT respondents smoked almost every day, with a higher prevalence in LGBT people in lower income households than those in higher income households (21% vs. 12%, respectively).
- 16% of LGBT respondents drank alcohol almost every day, with a higher prevalence in GBT men compared to LGBT women (20% vs. 13% respectively).
- 13% of younger LGBT respondents (aged 18-24 years) took drugs at least once a month.

Access to and experience of health services

- There is evidence that LGBT people are more dissatisfied with health services compared to the heterosexual population[92]. As identified by the 2018 National LGBT Survey and a 2016 review of inequalities of LGBT groups in the UK[93]:
- Long waiting lists for mental health and gender identity services
- Specific LGBT health needs not being taken into account or adequately understood by healthcare professionals – e.g., the need for timely access to post-exposure prophylaxes (PEP) for HIV prevention. (This lack of understanding and support, including lacking knowledge in GPs of the available services and routes to access, was found by the Stonewall survey to be a particular problem for trans people[94]).
- Experiences or fear of discrimination, with the result that many LGBT people avoid healthcare services (18% of respondents to the National LGBT Survey said that they avoided treatment due to discrimination concerns).
- The above may result in LGBT people preferring and engaging more with specialist LGBT services over mainstream services.

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[90] National Institute of Economic and Social Research (2016). Inequality among lesbian, gay bisexual and transgender groups in the UK: a review of evidence.
[91] Stonewall (2018). LGBT in Britain: Health Report.
[92] National Institute of Economic and Social Research (2016). Inequality among lesbian, gay bisexual and transgender groups in the UK: a review of evidence.
[93] Stonewall (2018). LGBT in Britain: Health Report; National Institute of Economic and Social Research (2016). Inequality among lesbian, gay bisexual and transgender groups in the UK: a review of evidence.
[94] Stonewall (2018). LGBT in Britain: Health Report.

- The Stonewall report also found concerns around discrimination and invasive questioning meaning that some LGBT aren't open with healthcare providers about their sexuality or gender identity[95].
- The LGBT Foundation suggest that community pharmacies are in a strong position to address health inequalities and improve the healthcare experiences of LGBTQ+ people as most of the population are within 20 minutes of a pharmacy (either by driving, walking or using public transport) and there is no need to register or make an appointment, making them one of the most accessible types of healthcare. To ensure all patients feel welcomed, included and affirmed, small changes can be made such as using open, non-gendered language, not making assumptions and creating a visibly inclusive space to let LGBT patients who that they are safe to share their identity[96].

Safety and discrimination

- In addition to discrimination, experienced or anticipated, in healthcare, LGBT reported a greater risk from hate crime in everyday life. Two-fifths of respondents to the National LGBT Survey reported experiencing an incident due to their sexuality or gender orientation in the last 12 months (such as verbal and physical attack)[97]; the review of LGBT inequalities identified gay men, younger LGBT people and those from black and ethnic minority groups to be at particular risk of hate crime[98].
- Homelessness and access to housing provision[99]
- Although some may perceive LGBT people as being more at risk of homelessness, the review of LGBT inequalities found only weak evidence. Homo-, bi- and trans-phobic abuse, however, was found to be a significant reason for homelessness, with young people who were 'coming out' identified as an at-risk group.

Marriage and civil partnership

No specific health needs were identified in relation to marital status.

[95] Stonewall (2018). LGBT in Britain: Health Report.
[96] LGBT Foundation (2022). Pride in Pharmacy. Developing LGBTQ+ inclusion within community pharmacies. Pride in Pharmacy
[97] Government Equalities Office (2018). National LGBT Survey.
[98] National Institute of Economic and Social Research (2016). Inequality among lesbian, gay bisexual and transgender groups in the UK: a review of evidence.
[99] National Institute of Economic and Social Research (2016). Inequality among lesbian, gay bisexual and transgender groups in the UK: a review of evidence.

Health Issues of Additional Groups (Non-Protected Characteristics)

Gypsy, Traveller and Roma communities

- A government inquiry into the inequalities faced by Gypsy, Roma and Traveller communities found that these groups, although poorly represented in data collection, have the poorest health outcomes of all ethnic groups, in addition to the poorest education, employment and criminal justice outcomes[100].
- Evidence collected in this inquiry described poor access to healthcare, including GP services, immunisation services, maternity care and mental health provision. Reasons for this poor access included discrimination, difficulties navigating the NHS, language and literacy barriers, lack of trust, and a reluctance to seek medical attention until health problems had become serious.
- Gypsy and Traveller people have also described difficulties in accessing General Practice without a fixed address, with many relying on accident and emergency services and walk-in clinics to access medical care, sometimes travelling long distances or waiting a long time to be seen[101]. Data have also found that Gypsy and Traveller people are less likely to be satisfied with access to a GP and the service received compared to White British groups[102].
- Data from the 2021 census showed that twice as many Gypsy and Traveller people described their health as "bad" or "very bad" compared to the British group (12.5% vs. 5.2%)[103]. The age profile of Gypsies and Travellers is younger than the national average, with (at the time of the 2021 census) 45.7% aged 25 years or under (compared to 30.4% of the England and Wales population)[104]. Life expectancy has been estimated to be 10-12 years less than that of the non-Traveller population[105]

Refugees and Asylum seekers

- The adverse and traumatic experiences of refugees and asylum seekers can have significant impacts on the health of these groups. This includes:
    - physical issues and disabilities, such as bodily and head injuries and epilepsy;

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[100] House of Commons Women and Equalities Committee (2019). Tackling inequalities faced by Gypsy, Roma and Traveller communities.
[101] Office for National Statistics (2022). Gypsies and Travelles' lived experiences, health in England and Wales: 2022.
[102] UK Government (2019). Satisfaction with access to GP services.
[103] Office for National Statistics (2023). Gypsy or Irish Traveller populations, England and Wales: Census 2021.
[104] Office for National Statistics (2023). Gypsy or Irish Traveller populations, England and Wales: Census 2021.

[105] UK Parliament (2019). What we know about inequalities facing Gypsy, Roma and Traveller communities.

    - mental health problems, such as depression and post-traumatic stress disorder (PTSD);
    - malnutrition and anaemia;
    - untreated noncommunicable diseases; and
    - communicable diseases[106].
- Refugees and asylum seekers may also have poorly controlled chronic conditions, badly healed injuries, may have run out of medications or be missing certain vaccinations[107] The high burden of disease in these groups is often compounded by poor access, delays and exclusion from healthcare in the receiving country. In the UK, refugees and asylum seekers with an active application or appeal are entitled to free primary and secondary care on the NHS, whilst refused asylum seekers are not necessarily entitled to free secondary NHS care[108].
- However, practical issues, such as language barriers, access to interpreters, poor awareness about the services available, difficulties in accessing transport (including those relating to language), real or anticipated discrimination, and culturally insensitive communication and care can act as barriers to access[109]. Moreover, the care provided may not be adequate for the health challenges faced by refugees and asylum seekers, particularly with regards to traumatic experiences and higher rates of poor mental health[110].
- There are also particularly vulnerable people within refugee and asylum-seeking groups, such as children and older people, those with disabilities, and those who are pregnant.

Those living in more deprived areas (including children living in poverty)

Overall effect of deprivation

- As discussed in the 2010 *Fair Society, Healthy Lives: The Marmot Review* of health inequalities, there is a clear social gradient in health, whereby those who face greater deprivation in their lives experience poorer health outcomes[111]. This is apparent right at the start of life, with infant mortality rates nearly three times higher in the 10% most deprived areas compared with the 10% least deprived[112] and through the life-course, with inequalities in life expectancy, healthy life

[106] Langlois et al. (2016). Refugees: towards better access to health-care services.
[107] BMA (2024). Refugee and asylum seeker patient health toolkit. Unique challenges for refugees and asylum seekers.
[108] British Medical Association (2022). Refugees' and asylum seekers' entitlement to NHS care.
[109] The Kings Fund (2022). What are health inequalities?; Langlois et al. (2016). Refugees: towards better access to health-care services
[110] Equality and Human Rights Commission (2010). Refugees and asylum seekers: a review from an equality and human rights perspective.
[111] Marmot et al. (2010). Fair Society, Healthy Lives (The Marmot Review).
[112] Office for National Statistics (2024). Child and infant mortality in England and Wales: 2022.

expectancy and disability-free life expectancy between the most and least deprived. In the most deprived areas in England, 36.9% of females and 38.7% of males reported being in very good health compared to 55.4% of females and 55.6% of males in the least deprived areas[113]. Those from the more deprived groups are also more likely to experience long-term health conditions, have more than one long-term health condition and develop these earlier in life, and are more likely to die from an avoidable cause (such as cancers, CVD etc.) than their least deprived peers[114].

Behaviours and wider determinants

- The prevalence of risky health behaviours is often greater in more deprived groups, with the exception of alcohol use:
- *Alcohol use* – drinking alcohol at increasing and higher risk levels has been found to be more common in the least deprived groups[115]. Admissions to hospital where the primary diagnosis or any of the secondary diagnoses are due to an alcohol-specific condition are significantly more likely among the most deprived groups compared to the least deprived groups (in 2023/24, 858 per 100,000 in the most deprived decile compared to 486 per 100,000 in the least deprived decile).
- *Obesity* – adults living in the most deprived areas are most likely to be obese. This is a particular issue in women, with obesity in 39% of those living in the most deprived areas, compared to 22% in those living in the least deprived areas[116]. Children living in the most deprived areas are more than twice as likely to be obese compared to children living in the least deprived areas[117].
- *Smoking* – nearly three times more prevalent in the most deprived 20% of the population, compared to the least deprived 20%[118] and smoking before or during pregnancy is more likely in mothers from routine and manual occupations[119]. Child health is further affected by lower levels of health protective behaviours; mothers from routine and manual occupations are also less likely to breast-feed than their wealthier peers[120].
- Risky health behaviours tend to cluster in more deprived areas, and are influenced by the poorer social, economic and environmental conditions that more deprived communities experience (the wider determinants of health).

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[113] Office for National Statistics (2023). General health by age, sex and deprivation, England and Wales: Census 2021.
[114] The Kings Fund (2022). What are health inequalities?
[115] NHS Digital (2020). Statistics on Alcohol, England 2020.
[116] NHS Digital (2020). Health Survey for England 2019.
[117] NHS Digital (2024). National Child Measurement Programme, England, 2023/24 School Year
[118] The Kings Fund (2022). What are health inequalities?
[119] Office for National Statistics (2020). Child and infant mortality in England and Wales: 2018.
[120] Office for National Statistics (2020). Child and infant mortality in England and Wales: 2018.

These conditions include less access to green space, higher concentrations of fast-food outlets, more limited availability of affordable healthy food, overcrowding, fuel poverty, air pollution and many others[121].

Causes of mortality

- More deaths in those living in the deprived areas are due to heart disease, lung cancer and respiratory diseases, compared to those living in less deprived areas. Risk factors, such as smoking, are higher amongst deprived groups[122].

Access to and experience of health services

- Some groups in the population face systematic differences in the quality of healthcare received and barriers to accessing it; these groups often overlap with those who may be more likely to live in more deprived communities, such as people of minority ethnicities, asylum seekers and refugees, and Gypsy, Roma and Traveller communities[123].
- More deprived areas in England have been found to have fewer GPs per head (and people from these communities have a lower likelihood of reporting good experiences of GP visits) and may not receive enough planned care compared to those living in less deprived areas, indicated by the greater likelihood of emergency hospital admissions compared to elective care[124].
- Evidence suggests that there are more claims for NHS contractual services by community pharmacies in England in the most deprived areas (17%) compared to the least deprived areas (5%). However, there have also been more pharmacy closures in the most deprived areas compared to the least deprived areas which could potentially exacerbate health inequalities[125]

Mental health

- Rates of mental ill health are greater in those who are more deprived and may be compounded by poorer conditions in their living environment (e.g., safety) and by unstable and low pay jobs[126].
- Children from more deprived families also exhibit greater risk of mental health issues, with those in the lowest fifth of income distribution groups more than

[121] Office for National Statistics (2020). Child and infant mortality in England and Wales: 2018.
[122] Office for National Statistics (2017). How does deprivation vary by leading cause of death?
[123] The Kings Fund (2022). What are health inequalities?
[124] Nuffield Trust (2018). Poor areas left behind on standards of GP care, research reveals.
[125] The Pharmaceutical Journal (2023). Pharmacies in England's most deprived areas provide 50% more NHS services their local populations.
[126] Public Health England (2018). Health matters: reducing health inequalities in mental illness.

four times as likely to experience severe mental health problems compared to those in the highest fifth[127].

- Living in a deprived area increases the risk of suicide amongst nearly all working age adults, however the risk is highest among those aged between their late 30's and late 40's. Among people of this age, the risk of suicide among people living in the most deprived areas is more than double that of people living in the least deprived areas[128]. The risk of suicide is influenced by a complex mix of social, cultural, psychological and economic factors, however unemployment, economic uncertainty and unmanageable debt have been found to be key risk factors for suicidal behaviour among men[129].
- Attempted suicides in young people from more deprived backgrounds have also been found to be double those of less deprived backgrounds, although there appears to be no difference in prevalence of self-harming linked to deprivation[130].

Unemployment

- Compared to those in work, long-term unemployment is associated with lower life expectancy and poorer physical and mental health. People who are unemployed are nearly six times more likely to report poor health than those who are employed (14.1% vs. 2.4%)[131]. Lack of employment, education or training in young people (NEET) is also associated with poorer health and the risk of low income later in life[132].

Carers

- Estimates of the numbers of unpaid or informal carers in the population vary (e.g., extrapolating from the 2021 census, approximately 73,000 people are unpaid carers in West Sussex, representing 8.6% of the population, whilst the GP Patient Survey puts this figure at 16% of the population). As the population ages, the number of older people who are informal carers is growing, particularly in those aged 85 and over. This group may not recognise themselves as carers, however, and may be at increased risk of isolation, loneliness and mental health issues [133]

Health and long-term conditions

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[127] Gutman et al. (2015). Children of the new century: Mental health findings from the Millennium Cohort Study.
[128] Office for National Statistics (2020). How does living in a more deprived area influence rates of suicide.
[129] Office for National Statistics (2020). How does living in a more deprived area influence rates of suicide.
[130] Gutman et al. (2015). Children of the new century: Mental health findings from the Millennium Cohort Study.
[131] The Health Foundation (2024). How employment status affects our health.
[132] Public Health England (2017). Health profile for England: 2017.
[133] Age UK (2019). Policy Position Paper: Mental Health (England).

- The self-reported health of people providing unpaid care becomes worse with increasing hours of care given[134].
- Long-term conditions are more prevalent in carers than non-carers (in West Sussex in 2019, 62.5% of carers reported a long-term condition, compared to 50% of non-carers) and carers are at risk of poorer mental and physical health[135]. Analysis of the 2021 GP Patient Survey by the Carers UK charity found[136]:
- *Physical health* – carers were more likely to report were musculoskeletal issues (arthritis or ongoing back or joint problems) and high blood pressure than non-carers and a greater proportion of carers reported problems with their physical mobility
- *Mental health* – a greater proportion of carers reported a long-term mental health condition than non-carers
- Additional research conducted by Carers UK identified the significant negative impacts on mental health due to caring, with around 70% of carers experiencing mental health issues, such as stress or depression, due to caring and around 80% of carers reporting feeling lonely or socially isolated due to their caring role[137].

Access to healthcare

- In West Sussex, according to the 2019 GP Patients' Survey[138]:
- Fewer carers report an overall good experience of making a GP appointment compared to non-carers and lower satisfaction with the type of appointment offered.
- More carers than non-carers attempt to access an NHS service when their GP practice was closed, either for themselves or someone else.
- More carers than non-carers have a preferred GP, although fewer carers report seeing their preferred GP always or almost always.

Students

- West Sussex is home to the University of Chichester, with other universities just over the county border in Brighton and Hove. Students are often a transient population but may spend more time living at their university address during the

[134] Office for National Statistics (2024). Unpaid care expectancy and health outcomes of unpaid carers: England: April 2024.
[135] West Sussex County Council Public Health and Social Research Unit (2020). JSNA Summary 2019/2020.
[136] Carers UK (2022). Carers' health and experiences of primary care Data from the 2021 GP Patient Survey.
[137] Carers UK (2022). Carers' health and experiences of primary care Data from the 2021 GP Patient Survey.
[138] West Sussex County Council Public Health and Social Research Unit (2020). JSNA Summary 2019/2020.

academic year, so are encouraged to register with a local GP (including at the student health centre attached to their university) to enable swift access to healthcare, if needed. This is particularly pertinent for students who have an ongoing health condition that may need management or medicine, such as those with diabetes, epilepsy or asthma[139]. Particular health issues for students include:

Mental health

- The recorded prevalence of mental health issues in students has increased significantly in recent years, with females more likely to report mental health conditions than males[140]. Whilst some of this increase may be attributable to a rise in reporting, as awareness of mental health issues increases and stigma decreases, there is evidence that these rises still do not show the full picture of poor mental health in student populations; although the number of UK university applicants sharing a mental health condition with the Universities and Colleges Admissions Service (UCAS) increased by 450% in the last decade, a UCAS survey of first year students found nearly half of respondents had a mental health condition but had not disclosed this to their university[141]. Aside from concerns around disclosure negatively affecting their application, reasons for this reluctance to share included concerns around stigma, not having a formal diagnosis and feeling that their condition was not serious enough to disclose.
- Surveys of student health show large proportions of respondents reporting depression, anxiety disorders, loneliness and being worried often or all the time, as well as concerning behaviours such as thinking about self-harm and using alcohol or recreational drugs to cope with problems[142].

Sexual and contraceptive health

- Younger people, particularly university students, exhibit higher rates of risky sexual health behaviours, which puts them at greater risk of poor sexual health outcomes, including increased risk of contracting sexually transmitted infections (STIs), and, for females, at greater risk of unwanted pregnancies.

Rates of STIs are higher amongst young people; the rate of chlamydia, for example, is significantly higher in young adults than other age groups (in 2017, over 60% of chlamydia diagnoses in England were in 15-24 year olds[143] Young people may not screen regularly for STIs, however, which may increase the risk of onward infection

[139] NHS (2022). Getting medical care as a student.
[140] UK Government (2020). Support for students with mental health issues in higher education in England.
[141] UCAS (2021). Starting the conversation: UCAS report on student mental health.
[142] UK Government (2020). Support for students with mental health issues in higher education in England.
[143] Public Health England (2018). An STI is diagnosed in a young person every 4 minutes in England.

transmission and further complications such as pelvic inflammatory disease, ectopic pregnancy and infertility[144].

- Despite their increased risk of sexual health issues and access to on-campus sexual health services, many students may delay or avoid accessing services. Key barriers to accessing sexual health services include lack of awareness of available services, misconceptions of who services are for (e.g., age requirements and gender), inconvenient locations or opening times and personal perceptions. The latter is perhaps the most significant, and covers concerns about confidentiality/privacy, embarrassment at 'being seen', perceived stigma, and concerns that providers may not take them seriously and understand or respect their needs[145].
- There is some evidence that LGBT students may be less likely to access on-campus sexual health services compared to non-LGBT students, which may relate to uncertainty in when and for which illnesses to access sexual health services in the students and lack of knowledge in LGBT health issues in the providers[146].

Vaccination

- Inflows of people from different areas of the country at the beginning of the academic year increase the risk of some infectious diseases being transmitted within the student population, so vaccines are offered before young people begin their further studies to protect against meningitis, mumps and flu:
- MenACWY vaccination – 17 and 18 years olds in Year 13 and first-time university students up to age 25 are eligible.
- MMR vaccination – although most young people will have received the two doses of the MMR vaccine as part of the NHS childhood immunisation schedule, universities and colleges encourage students who are unsure of their vaccination status to ask a GP for a catch-up vaccine.
- Flu vaccination – those with serious long-term conditions and who have asthma and take inhaled steroids are advised to get a flu vaccination[147].

[144] OHID (2022). Sexual and Reproductive Health Profiles.
[145] Bender & Fulbright (2013). Content analysis: A review of perceived barriers to sexual and reproductive health services by young people.

[146] Cassidy et al. (2018). Barriers and enablers to sexual health service use among university students: a qualitative descriptive study using the Theoretical Domains Framework and COM-B model.
[147] NHS (2022). Getting medical care as a student.

Homelessness and Rough Sleepers

- People who sleep rough or experience homeless have significantly poorer health outcomes compared to the general population, with these groups often having multiple co-occurring health conditions and dying younger on average.
- As outlined in the LGA's guide on the impact of homelessness for local authorities, some groups are at particular risk of poor outcomes[148]:
- Groups already experiencing inequalities and difficult conditions are more at risk of homelessness, including young people leaving care, offenders, and people at risk of domestic violence.
- Children experiencing homelessness are at particular risk of long-lasting harm, with an increasing risk to health and wellbeing the longer a person is homeless.
- Young people are particularly vulnerable to harm and poor health, with increased risk of numerous issues, including mental health issues, self-harm, drug and alcohol use, sexually transmitted infections, and unwanted pregnancies. This group may face exploitation, abuse and other harms.

Physical health

- The prevalence of most causes of long-term poor physical health is greater in homeless people, with the Homeless Link charity's 2022 Health Needs Audit finding that 63% of homeless people reported having a long-term illness, disability or infirmity, compared to 22% of the general population[149].
- Compared to the general population, the prevalence of infectious diseases (such as TB, HIV and hepatitis C) is greater in rough sleepers, as is the risk of certain conditions, such as musculoskeletal disorders, skin and foot problems, dental problems and respiratory illnesses[150]. Older adults who are homeless may also have existing health conditions made worse by homelessness and are more likely to experience depression and dementia[151].
- Risky health behaviours, such as smoking and alcohol use, are also more likely in homeless people. Homeless Link's 2022 audit found that[152]:
- Over three-quarters of homeless people smoke (compared to 13.8% of the general population),
- Nearly a third of respondents reported that they had, or were recovering from, an alcohol problem

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[148] Local Government Association (2017). The impact of homelessness on health: A guide for local authorities.
[149] Homeless Link (2022). The Unhealthy State of Homelessness 2022. Findings from the Homeless Health Needs Audit.
[150] Public Health England (2020). Health matters: rough sleeping.
[151] Local Government Association (2017). The impact of homelessness on health: A guide for local authorities.
[152] Homeless Link (2022). The Unhealthy State of Homelessness 2022. Findings from the Homeless Health Needs Audit.

- Less than a fifth of respondents ate three or more meals a day, with a third reporting that on average they only ate one meal a day
- Women experiencing homelessness are less likely than the general population to access cervical or breast screening
- Just under a quarter of respondents had a sexual health check in the previous year

Mental health and substance misuse

- The prevalence of mental health issues is significantly higher in homeless people (Homeless Link's 2022 audit found that 82% had a diagnosed mental health condition) and may often be part of a 'dual diagnosis' with substance misuse problems. Homelessness and rough sleeping combined with substance misuse may increase the risk of additional poor health outcomes and comorbidities, including greater risk of blood-borne viruses[153].

Causes of death

- Causes of death in homeless people differ from those of the general population. In 2020, nearly 40% of deaths were related to drug poisoning, around 12% to alcohol-specific causes (a figure which has been rising over the last decade) and nearly 11% to suicide[154].
- A 2019 analysis of deaths of homeless people in England found nearly a third of deaths were due to conditions that amenable to timely healthcare, such as TB and gastric ulcers[155]. This study also showed significant morbidity from cardiovascular disease, cancer and digestive diseases, and double the likelihood of death from a stroke, compared to people living in the most deprived areas who had a home.

Access to services

- Homeless people are reported to visit accident and emergency departments and be admitted to hospital at significantly higher rates than the general population (particularly for those who are homelessness and dependent on alcohol), whilst access to primary care is significantly lower in homeless people[156].
- A third of rough sleepers are not registered with a GP and many ascribe this to not having a fixed address[157]; Homeless Link's audit also found not having

[153] Public Health England (2020). Health matters: rough sleeping.
[154] Office for National Statistics (2021). Deaths of homeless people in England and Wales: 2020 registrations.
[155] Aldridge et al. (2019). Causes of death among homeless people: a population-based cross-sectional study of linked hospitalisation and mortality data in England.
[156] Public Health England (2020). Health matters: rough sleeping.
[157] Public Health England (2020). Health matters: rough sleeping.

identification or proof of address, having missed a previous appointment and behaviour as reasons for which homeless people had reported being refused access[158]. Those with mental health issues and co-occurring substance misuse problems may also face additional barriers in accessing substance misuse treatment services.

[158] Homeless Link (2022). The Unhealthy State of Homelessness 2022. Findings from the Homeless Health Needs Audit.