Coastal ACTION

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MAKING HEALTHIER
COASTAL COMMUNITIES

Improving the NHS and Health in Hastings & Rye

Practical measures for making healthier coastal communities

James Prentice

POLICY PAMPHLET



FINDING SOLUTIONS TO THE
POLICY PROBLEMS HARMING
COASTAL COMMUNITIES

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Health & the NHS

Out of the top 20 local authorities in England and Wales with the highest proportion of individuals in poor health, 10 are in coastal communities[1]. The most recent report into coastal communities submitted to parliament highlighted that these areas possess a unique set of challenges. Firstly, 20% of these localities' population is over 65 years old, compared to the 16% nationally[2]. Secondly, they also tend to be exposed to higher levels of isolation, loneliness, unemployment and benefit dependence, something that is thought to contribute to the higher-than-average mental health caseload[3]. Thirdly, they also tend to have high drug dependency problems, larger levels of smoking, higher obesity rates and greater homelessness challenges. Together, these health and socio-economic challenges interact to produce multiple unique health challenges within relatively small areas. This puts pressure on an already stretched NHS, creating challenges to effectively address health needs.

Health in Hastings:

Hastings is one of those 10 coastal communities identified to be in the top 20 areas of very poor health. It would seem that people in Hastings agree, with only 42.5% describing their health as "very good", 5% less than the national average[4]. The East Sussex joint needs assessment also highlights how health in general in Hastings is significantly poorer than compared to the county, regional and English average[5]. As this is the case for a range of health metrics, it indicates the borough not only has poor general health, but also possesses multiple health problems that lead to worse outcomes.

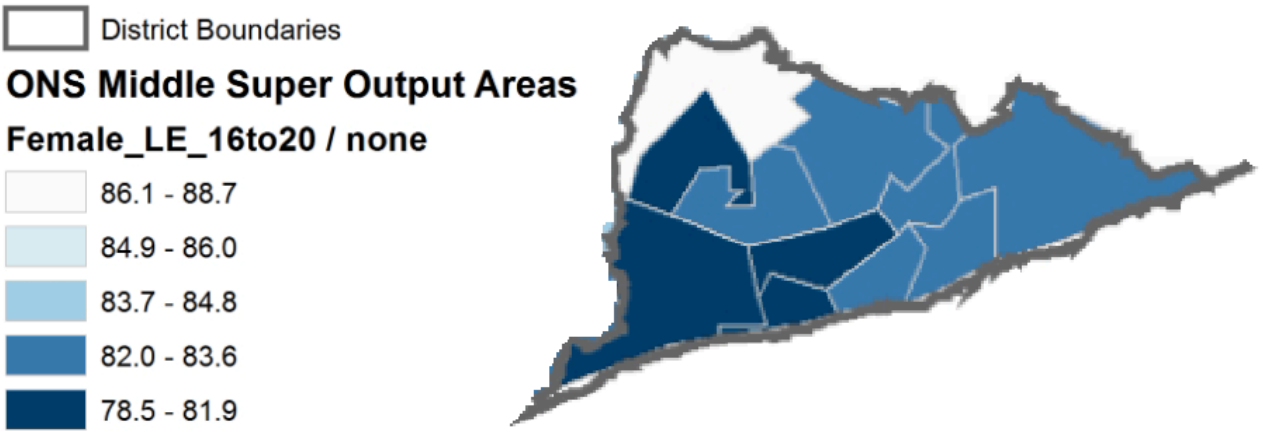


Figure 6.1: The range of Life expectancy within England (Per Middle Super Output Layer). Source: ONS Health profile data, Hastings.

Life expectancy for both men and women is below the national average. Men live 3 years less than the national average, and women 2 and a half years[6]. Comparing the most deprived areas in Hastings to the least deprived, life expectancy is 9.5 years lower for men and 6.9 years less for women, see Figure 6.1[7]. The leading cause of death is heart failure and disease[8]. It is also the leading cause of premature deaths for the under 75s, which is concerning given the cardiac unit in Hastings' Hospital (the Conquest) is due to be moved to Eastbourne[9]. Worryingly, according to NHS Sussex figures, life expectancy is now slightly lower than it was in 2013, with women being disproportionately affected[10]. This may be partly because the percentage of adults classed as overweight or obese is 2.1% higher than the regional average, with it also being significantly above the national average[11]. The prevalence of obesity in children is also high. The proportion of children defined as being obese or severely obese stood at 19.3% (195 recorded cases) in the last NHS report, 2.5% higher than average[12]. Importantly, this highlights how poor health is not only occurring amongst the elderly. Interestingly, these figures were recorded despite the diabetes diagnosis rates being significantly below the national average. This means that the true proportion of overweight and obese adults may actually be higher. The proportion of adults being physically active is also 3.7% below the national average, compounding obesity-related problems[13].

Life expectancy and causes of death

Indicator	Age	Value (Local)	Value (Region)	Value (England)
1 Life expectancy at birth (male)	All ages	77.1	80.7	79.6
2 Life expectancy at birth (female)	All ages	81.6	84.1	83.2
3 Under 75 mortality rate from all causes	<75 yrs	445.0	292.3	330.5
4 Mortality rate from all cardiovascular diseases	<75 yrs	102.3	59.0	71.7
5 Mortality rate from cancer	<75 yrs	161.2	123.6	132.3
6 Suicide rate	10+ yrs	15.7	9.21	9.64

Figure 6.2: Indicators of poor health outcomes. Hastings compared to the national average. Source: Public Health England.

Additionally, rates of smoking in adults are 2.6% higher than the national average and 4.4% greater than the county average[14]. The percentage of individuals smoking during a pregnancy is also significantly higher than the national average, 4.8%[15]. The borough also has significantly worse rates of alcohol-related mortality, with hospital admissions due to alcohol also being greater than average[16].

Such behavioural choices can help to explain the significantly higher mortality rates from cardiovascular diseases and cancers. In the most recent health report, there were 102 deaths per 100,000 people within a one-year period. For deaths from Cancer, it was 161, See Figure 6.2. This has partially led to a mortality rate for those under 75 of 445 (per 100,000 people), way above the national rate of 292[17]. It may also help to explain the slightly higher-than-average infant mortality rate. Hastings has a high count of STI diagnoses. 511 cases were identified in the last year of recording, resulting in a rate of 874 cases per 100,000 people[18]. Further, the teenage conception rate is well above the national average, with there being 30 cases per 1,000 females aged 15 to 17, 13 more than the English average[19]. Whilst not all these pregnancies will have been unplanned, this, along with the high STI and obesity rates, does highlight how individual choices are increasing pressures on the health service.

Yet, individual choices can only go so far to explain the disproportionate health challenges Hastings faces. Public Health England also identifies wider factors that can determine health outcomes and notes that the percentage of families in low-income households was much greater than the national average. Figure 6.3 emphasises how the proportion of children living in low-income families was 26.2% in 2023, well above the national average of 17%[20]. Therefore, the increased poverty in the town (see chapter 9) has exposed more people to factors that tend to produce worse health outcomes, partially explaining worsening health metrics. It also notes that education attainment was significantly below the national average and that the proportion of people in employment is 3 per cent lower than compared to the English average. Public Health England also highlights how the homelessness rate was 2.93, well above the national average of 0.79[21]. Further, it highlighted how violent crime was disproportionately higher than the English average. The Sussex joint strategic needs assessment has also outlined how, like many coastal communities, the Sussex coastline has a high proportion of people feeling lonely and isolated[22]. This can help to explain why, in 2019, 14.4% of GPs' caseload was recorded as mental health illnesses, double that of the national average[23]. Indeed, other metrics also demonstrate mental health cases to be significantly higher than the English average.

Wider determinants of health

Indicator	Age	Value (Local)	Value (Region)	Value (England)
25 Percentage of children in low income families	<16 yrs	26.2	12.9	17.0
26 Average GCSE attainment (average attainment 8 score)	15-16 yrs	40.9	47.9	46.9
27 Percentage of people in employment	16-64 yrs	72.0	78.4	75.6
28 Statutory homelessness rate - eligible homeless people not in priority need	Not applicable	2.93	0.66	0.79
29 Violent crime - hospital admission rate for violence (including sexual violence)	All ages	- ~	31.2 $	44.9

Figure 6.3: Indicators of wider factors that determine poor health outcomes. Hastings compared to the national average. Source: Public Health England.

All this, Public Health England argues, are signs of structural factors that lead to a greater prevalence of poor health outcomes.

Future health needs projections:

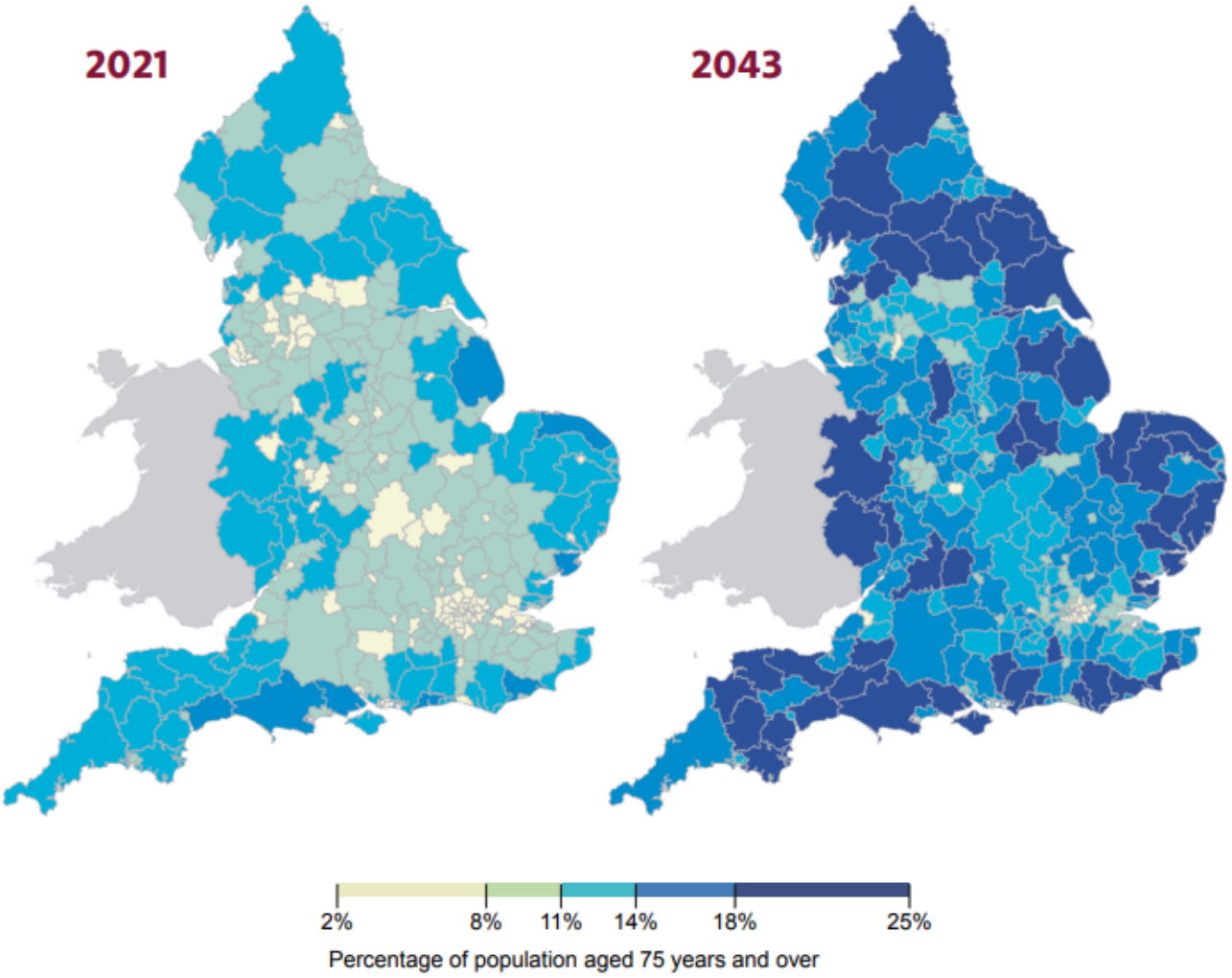
There are signs that the health challenges Hastings faces have been worsening for some time. Mortality that was considered preventable increased from 228 cases per 100,000 people in 2015 to 239 in 2019[24]. Such deaths caused by cardiovascular disease in the same period increased from 90 to 96 cases, despite cases falling nationally[25]. Respiratory diseases also increased slightly. Such outcomes, in part, may be because health in general appears to be worsening. From 2014 to 2019, the proportion of adults classed as obese grew by 8.2%[26]. Mental Health cases also became more prevalent. In the same period, GPs reported 5.4% more of their patients were diagnosed with mental health illnesses[27]. These are all signs that the progress made on health in the early 2000s has been lost, which possibly has occurred due to more limited funding post the financial crisis of 2007.

Coastal Communities are projected to have an ageing population, making it likely that places like Hastings will face growing health problems, see map x.1[28]. Additionally, the Sussex NHS Trust is projecting more individuals to be living with a long-term illness that limits activity. Post-pandemic, the figure stood at 20,525, a high figure given the population in the Hastings borough is only around 90,600 people[29]. Yet, this is projected to increase to 25,048 by 2035, with overall disability levels also projected to increase[30]. This is partly due to the pandemic, but also due to worsening overall health trends. Crucially, this highlights the growing health challenges coastal communities, especially deprived localities such as Hastings, will likely face in just a few years.

Longer-term future projections also anticipate noticeably higher than average rises in demand for care services. Firstly, with 25% of the population in coastal communities anticipated to be over 65, this will bring natural increases in demand for health services[31]. Older people (65+) are more likely to be living with more than one chronic health condition, with more than 50% living with two or more long-term illnesses. This is problematic for NHS

finances as the unhealthiest patients are the most expensive, with currently 3% of patients taking up 45% of the NHS budget. Currently, 50% of ESCC's budget is taken up by adult social care costs, meaning an ageing, less healthy population will also negatively impact council finances, further reducing local government's ability to deliver non-statutory services.

Further, deprivation factors that partly drive rising demand for health services are also projected to worsen in many coastal communities. Therefore, this will only push up demand for health services further. Additionally, these socio-economic challenges will make it harder to attract health professionals to the coast, meaning poor staff-to-patient ratios will likely worsen.[32] With Hastings being at the end of a poorly serviced railway line, this could particularly affect poorer parts of the borough[33]. Finally, climate change impacts are projected to hit the coast more than other parts of the country. Therefore, health challenges caused by a warming climate will likely impact places like Hastings much more severely[34]. Again, this causes future projections to estimate that coastal communities like Hastings will have higher-than-average rising demands, adding to an already heavy caseload of patients.



Map 6.1 A Map showing that coastal communities are disproportionately going to be affected by an ageing society. Source: The Chief Medical Officer's Annual Report 2023.

The current state of the NHS trust that serves Hastings:

Due to these health problems and future projections, the Sussex NHS trust faces multiple challenges in meeting the health needs of people living in Hastings. Therefore, the trust needs to perform highly if it is to be able to tackle the growing list of health problems Hastings faces. Sadly, like most trusts around the country, the Sussex NHS Trust is struggling to meet set standards and rising care demands. In recent years, Sussex NHS Trust has displayed several signs of distress.

GP waits:

For many, the first point of contact with the NHS is to see a GP. Waiting times to see a GP are not desirable. In early 2024, 4,403 people in Hastings & Rye waited more than a week to see a GP. This was 15% of all patient appointments[35]. Part of the reason for these waits is the number of patients per GP. In Hastings & Rye, the average number of patients each GP is responsible for is 3,086[36]. Indeed, the Old Town has one of the highest GP-to-patient ratios in the country[37], meaning there simply aren't enough GPs for the number of medical enquiries this number of patients will naturally have. This problem is worsened by the fact that the town has an ageing, more unhealthy population, meaning the public's demands to see a GP will naturally rise. These delays can become problematic as medical conditions can worsen. This means that these medical problems can become harder and more costly to address, putting further strain on the NHS. It has also meant that GPs' caseloads have become more challenging and more demanding. On top of this, due to the increasing GP-to-patient ratio, professionals have less time to treat each patient. This means that GPs are presented with more challenging cases with less time to address patients' needs. This has put additional pressure on the profession, causing some to retire early and others to leave, with professionals going into the private sector, and in some cases, abroad[38]. The pandemic has only hardened these trends, with many GPs reducing hours as they struggle to deal with their demanding caseload. The increased numbers reducing their hours and leaving the profession have not been met by newly qualified GPs. Indeed, fewer people enter the profession now than compared to 2015[39]. Consequently, this has left a vicious cycle. Not enough GPs exist to meet demand, thus creating a larger, more demanding caseload. Then, this reduces incentives to stay in and enter the profession, further worsening access to GPs. The answer may seem simple; to hire more GPs. But there are two barriers. Firstly, it takes a long time to train a GP. Secondly, the GP surgery has reduced as a total spend of the NHS, meaning many surgeries do not have the money to hire additional GPs, despite there being GPs looking

for work. Therefore, without changing the funding model, this problem may be hard to address.

Mental Health Service delays:

Mental health services have also received a higher caseload, putting mental health provision services within Sussex under severe strain. GPs have reported a higher share of their caseload being referred for mental health treatment, and it is estimated that 13% of the population has a common mental health disorder[40]. A&E departments have also experienced a 15% increase in people being referred due to mental health crises[41]. At the Conquest Hospital in Hastings, this is problematic as there is only one mental health room, which, according to patients, is not in good condition. This increased demand has created long waiting lists for mental health and neurodevelopment services. Adults face, on average, an 18-month delay in waiting to access services after being referred by a GP – the most common starting point for patients. Those facing the longest delays can wait nearly two years to access services[42]. This is in line with the national average. Professionals argue that delivery has not been helped as services have become centralised, with four local branches being merged into one centre in Sussex[43]. This loss of local services has led to silo-planning that often does not take local needs into account, meaning in some cases needs take longer to be met. Particularly, they argue this has led to cases not being effectively followed up, leading to people being passed around, delaying care and increasing the backlog[44].

Additionally, demands for Child and Adolescent Mental Health Services (CAHMS) have experienced a heavy increase in demand. This has led the Sussex NHS Trust to inform parents that after referral, waits to access services often take two years[45]. Those who have worked in the mental health profession for decades argue that these delays in accessing services are causing cases to worsen at the point of service delivery. They argue that this is causing the caseload that mental health professionals work with to increasingly be dominated by very challenging cases. This is putting a heavy burden on the profession, causing higher levels of burnout and staff turnover.

This worsens the problem of limited staff, making it even harder to address the rising, ever more complex caseload. This trend means that waiting lists continue to grow and services, once accessed, are more time-limited and less patient-specific. This helps to explain why nearly half (47%) of respondents rated their experience of finding and accessing support as difficult, with dissatisfaction rates of service provision also increasing[46].

This limits the quality of care and only makes it harder to address the growing mental health needs. In the most challenging cases, where patients require sectioned hospital ward care, staffing challenges might be producing horrible consequences. Since 2016, 369 mental health patients have taken their own lives, with coroners having called 15 times for the Sussex NHS Trust to improve care, with some cases citing multiple failings[47]. Specifically, some cases from the coroner, who has a statutory obligation to write to an NHS Trust when a failure is found, cited neglect and oversights that led to a preventable death[48]. The Coroner has also written letters to the Sussex NHS Trust outlining changes that needed to be made to prevent future preventable deaths[49]. A consistent theme within these letters outlined a lack of continuity in care, with cases often not being followed up by relevant agencies. Professionals in the mental health service argue this confirms their argument that centralisation of services is causing delays, some of which produce negative outcomes[50]. Another common cause regards delays to receiving care, with long delays around gender affirming healthcare being cited in high-profile cases[51]. Whilst some of the affected families are calling for an enquiry, it is not known the extent to which the failings of the Trust have led to an avoidable fatality, and how many times this has occurred. Importantly, all this presents the considerable challenges mental health provision faces and how patients' needs are often not being met.

Dentistry blackspots:

Dentistry also faces similar problems. Since 2020, Sussex NHS has lost 25 dentists. This has led to a scenario where there are 6,278 people for each dentist surgery[52]. 40% reported being unable to get access to a dentist, and

20% were forced to go private to get treatment[53]. Indeed, 12% reported dentists they approached were no longer taking patients, leaving tens of thousands of people in Sussex without dental care[54]. Figure 6.4 highlights how Hastings, Rye, Bexhill and Eastbourne are areas within Sussex particularly affected by this phenomenon. For those who could access a dentist, waiting times were often calculated in the number of weeks rather than the number of days. Again, the pandemic has exacerbated these trends, but it is important to note that people struggled to secure dental services before the outbreak of COVID-19. More recently, in early June 2025, BBC South East covered a story of how more NHS dentists have been lost in the Sussex and Kent area, with more people being unable to access an NHS dentist. Interviews with dentists outlined how more were going into private dental care and leaving the profession, with some leaving the country to practise elsewhere. The reason for the lack of NHS dentists is primarily due to funding, making it impossible to run an NHS-only service. Also, those in the profession argue that we have not trained enough new professionals, leading to a shortfall and, again, a reliance on migrant Labour, which is not always available. Once more, a lack of staff in the areas where demand is high and needs are being unmet is occurring. The inability of many to see a dentist has created a huge backlog, compounded by the pandemic, where dentistry could only operate at 25% capacity for several quarters in 2020/21[55]. Sussex NHS have admitted this has resulted in a “huge backlog” that will take a long time to clear. This long wait for many will worsen their teeth, meaning more invasive treatment will be required to rectify problems, making dentists’ caseloads more challenging. According to one Sussex NHS Trust report, this is causing some to leave the profession early, further worsening staff shortages and making the backlog harder to clear[56]. Training new staff will take time, and so will raising the finances to provide economic incentives for professionals to return to NHS care. All this means that the backlog of needed treatment, made worse by COVID-19, continues to go unaddressed and serious medical needs go unmet. This, in part, may help to explain decreasing life expectancy, as poor oral care can lead to worse outcomes, including premature deaths.

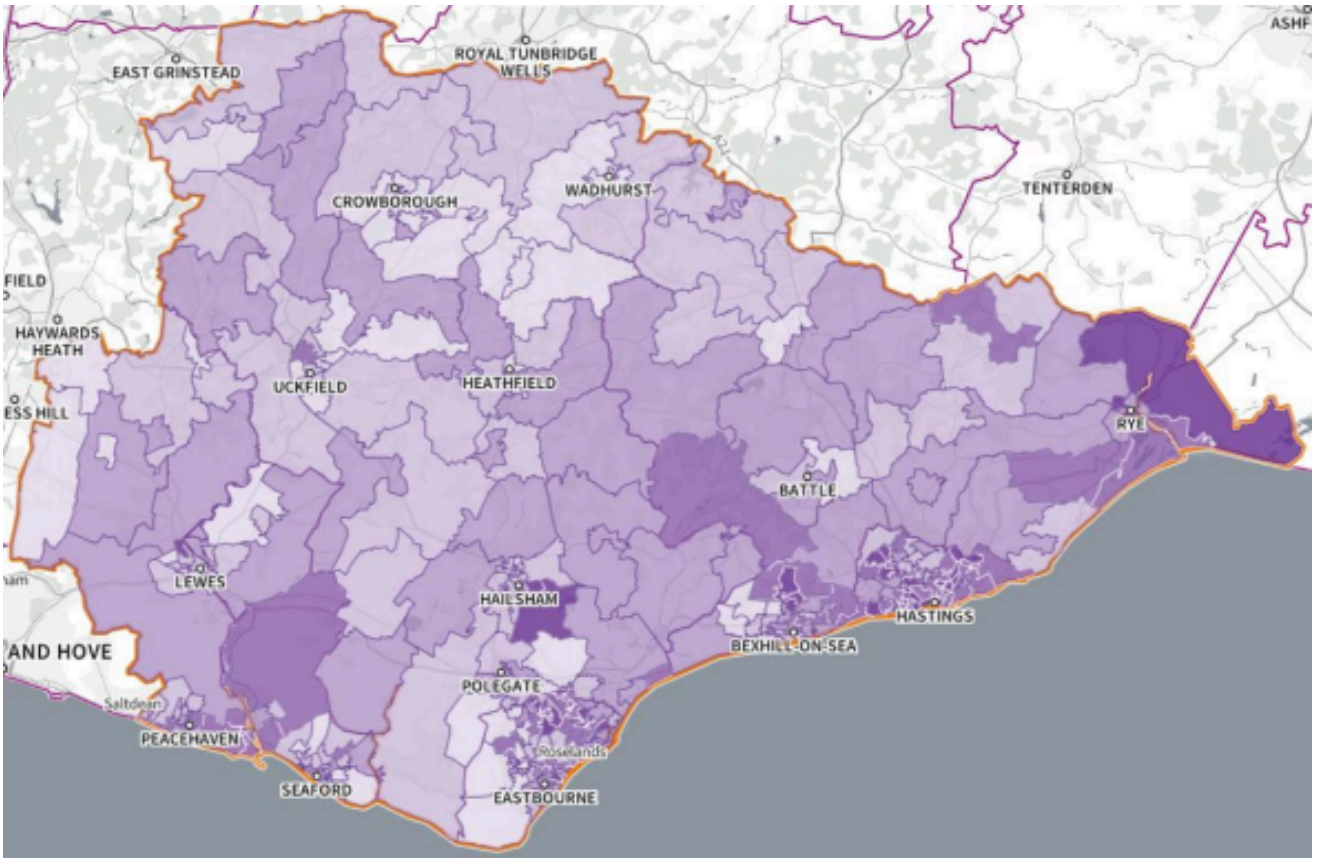


Figure 6.4: Dentistry accessibility in East Sussex. It shows Hastings has several blackspots, as do Rye, Bexhill and Eastbourne. Source: NHS Sussex Dentistry report, 2023.

Ambulance waiting times:

Ambulance waiting times in Hastings & Rye have also deteriorated. In 2024, Category 1 patients, cases that include life-threatening conditions like cardiac arrest and serious allergic reactions, faced an average waiting time of 9 minutes, missing the 7-minute target by quite some distance[57]. Category 2 patients, which can include stroke and major burn patients, waited an average of 34 minutes, way over the 18-minute target[58]. There are particular hotspot areas where waiting times can be even longer. In Rye, average ambulance waiting times in 2024 were 15 minutes for category 1 patients and category 2 patients faced an average wait of 45 minutes, see Figure 6.5[59]. Once arrived at the hospital, handover times (the time the ambulance takes to get the patient into the hospital's care after arrival) have also increased. In 2024, the number of handovers missing the 15-minute target was 2,918 - 64% of all

handovers[60]. The number of handovers taking 15-30 minutes was 2,021 – 52%, and handovers taking longer than 30 minutes were 498 – 16% of all handovers[61]. These delays in the system are partly caused by ambulances waiting in the car park due to the delays in the hospital, making it more time-consuming to transfer patients. These delays then cause a backlog of ambulances in the hospital entrance area and worsen handover times throughout the day. This then makes it harder to deliver ambulances to people on time, further causing longer than necessary waits for those in need. Indeed, research into increasing handover times has found that small increases in transitions can result in large delays to ambulance response times[62].

This is increasing the risk of longer-term illness and injury for patients. This is something that may increase healthcare needs over time, putting further burdens on the service. For the most serious cases, this may increase the risk of death. For cases deemed less serious, this can lead to hours of waiting. These cases are categorised as category 3 or 4 and, on average, face up to 180-minute waits. This is why stories of elderly people being left in the cold for hours for an ambulance to arrive have become common in local media. The cause of these delays is partly because worsening health trends are creating more severe cases, putting severe pressure on SECAMB's ability to respond to all incidents. Again, the more demanding caseload is putting pressure on staff, causing a higher staff attrition rate and creating shortages. This means the staff needed to address the higher amount of calls, which just isn't there. Further, the delays elsewhere in the system, especially the GP and A&E system, have resulted in patients looking elsewhere for better treatment, resulting in a higher volume of cases that is harder to address. Those who feel they can bypass A&E often find themselves delayed in long handover times, only to then find themselves in A&E post-transition. This only further reduces the number of ambulances available to deal with the increased demand and extends A&E waiting times, making it harder to deliver effective services.

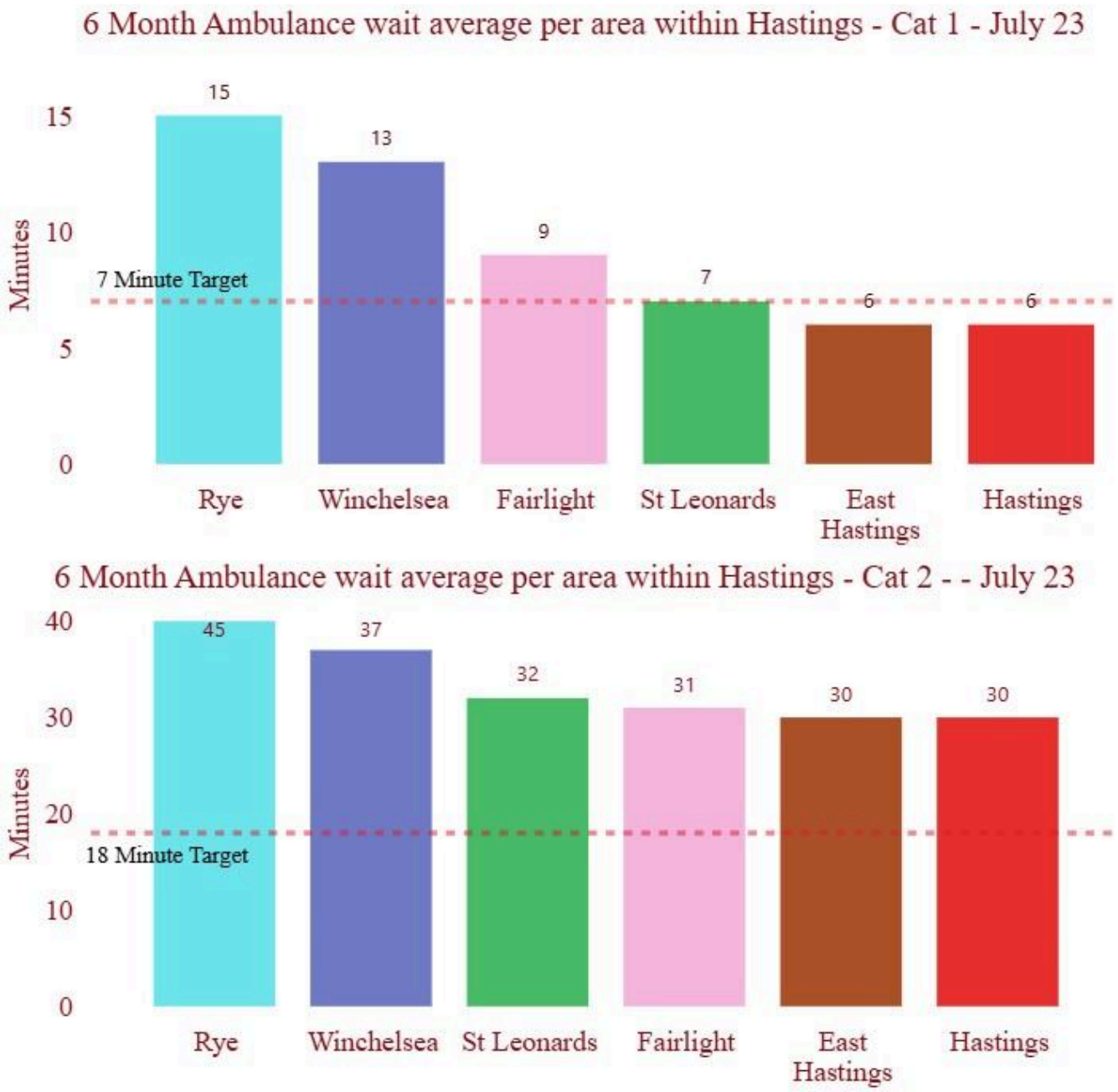


Figure 6.5: Ambulance waiting times in the Hastings & Rye area, January – July 2023. Source: FOI to SECAMB.

A & E waiting times:

Once in hospital care, a patient will likely face far too long waiting times. The target for waiting times in A&E is 4 hours, and the East Sussex NHS Trust has not hit these targets since 2014. In 2010, the trust dealt with 95% of cases within the 4-hour target and in 2024, it only dealt with 72% of cases within this time[63]. Since 2012, 20% fewer cases have been seen on time, see Figure

6. Indeed, on specific days where it is harder to recruit staff, waiting times can be much longer than the four-hour waiting target, sometimes increasing to 6 or 7 hours. The long waits in A&E are a sign that wider NHS hospital services are under severe pressure. Firstly, it highlights how there is a lack of staff within hospitals to manage both A&E care needs and the needs of patients who have been hospitalised. The lack of staff has been caused for similar reasons to those of GP surgeries. The ageing, unhealthier population has put a great deal of strain on NHS services. This has created high bed occupancy rates, causing a high and difficult workload. At peak times, bed occupancy is at the point where there simply are not enough beds for medical needs. Spare bed capacity can be hard to find due to the problems of returning people to social care. In short, new funding cuts (£11.5m in East Sussex)[64], staff shortages and limited placements for social care mean people in hospital requiring social care often have nowhere to go. Therefore, they remain in hospital to receive the care they still need, which means their condition is likely to worsen. People in hospital can't be moved to the most adequate wards for their needs, and others are left without a ward to go to, creating a bottleneck problem. In peak demand points within a typical year, this frequently occurs. Indeed, a report into social care patients in East Sussex hospitals noted "too many patients were being cared for in an inpatient hospital bed when there was no longer a health-related need for them to do so[65]." Nationally, it is estimated that 13% of hospital beds are blocked due to an immediate lack of social care, something that is thought to put pressure on A&E services and causes 268 excessive deaths per week[66].

Again, such pressures increase staff sickness and burnout rates, leading to a higher turnover of staff. Again, some staff leave for the private sector, and others have gone abroad to practise. This only increases the workload burden on the staff remaining in the system, again, creating a vicious cycle where staff leave and the working environment deteriorates. Then, staff lose their morale as they feel they can't provide the care and compassion that motivates them, incentivising more staff to leave. Yes, the staffing problem can be fixed by hiring more workers. Yet, it takes time to train professionals to

work in a hospital environment, and due to the difficult working environment, professionals often seek employment elsewhere. Therefore, staffing challenges are ongoing, and hospitals continue to struggle to meet increasing demand.

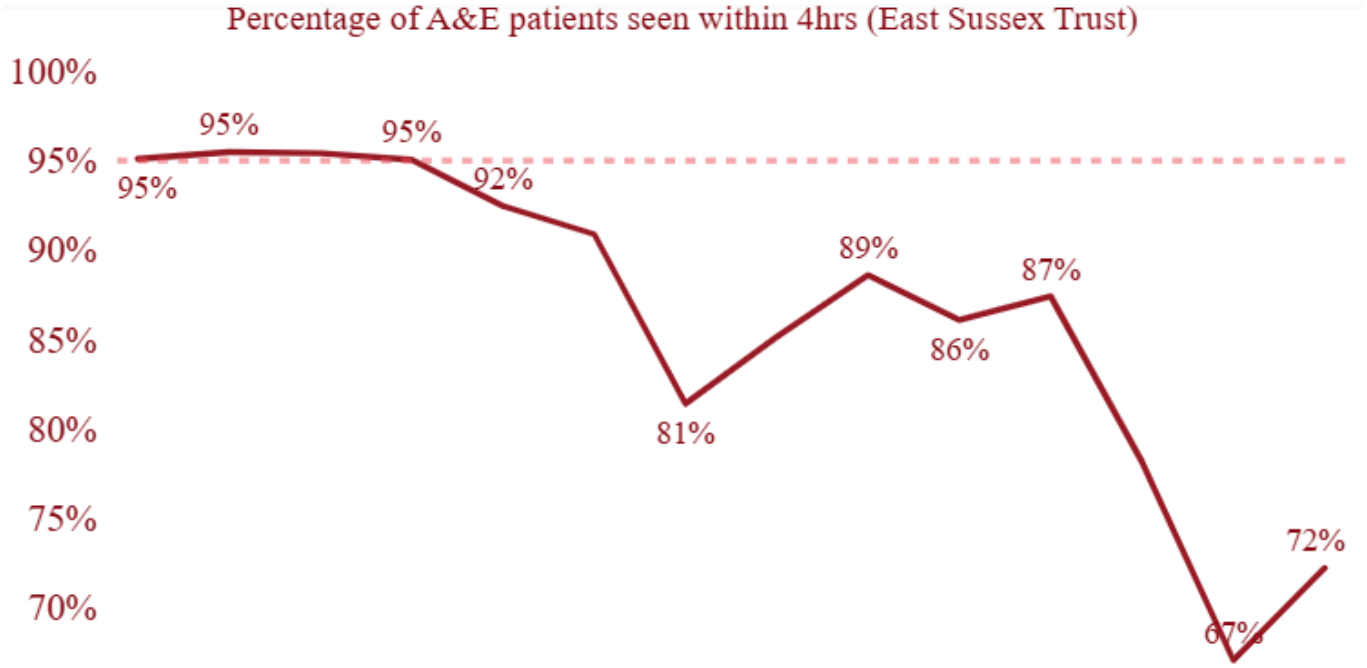


Figure 6.6: Percentage of A&E patients seen within 4 Hours in the East Sussex NHS Trust, 2010 - 2023. Source: NHS England Data.

Treatment waits:

Waiting times for treatment have rocketed. The proportion of patients seen within 18 weeks has declined from 96% in 2014 to 56% in 2024[67]. This greatly misses the set standard of 90%, meaning that people needing treatment are waiting longer, sometimes with a reduced quality of life. For instance, those requiring surgery to deal with mobility problems can often go months before their quality of life can be improved through surgery. The average waiting time for all treatments in 2014 was 18 weeks, with it rising to 48 weeks in 2024[68]. For specific treatments, average waiting times can be even longer[69]. Ear, Nose and Throat (ENT) operations by 2024 had an average waiting time of 48 weeks. Gastroenterology 51 weeks, Gynaecology 52, Neurology 49, Trauma 44, Urology 55 and general surgery 52 weeks[70]. Figure 6.7 clearly shows that the Pandemic had a great impact on causing times to increase. But, it should also

be noted that even before the pandemic, waiting times rose, and post-pandemic, they have proven very hard to decrease. These delays were originally created by a combination of underinvestment, a lack of new staff and increasing care demands from an ageing population. The pandemic further delayed those waiting for treatment.

The increasing waits for treatments are incredibly important as they impact all the other problems discussed in this chapter. The inability to get treatment within an adequate waiting time means that illnesses go untreated, meaning they can worsen and become harder to treat. This can cause the NHS to spend more time treating patients, as those needing treatment are forced into recurring visits to manage their health problems. This only puts greater pressure on GP surgeries, A&E departments, treatment centres and hospital units.

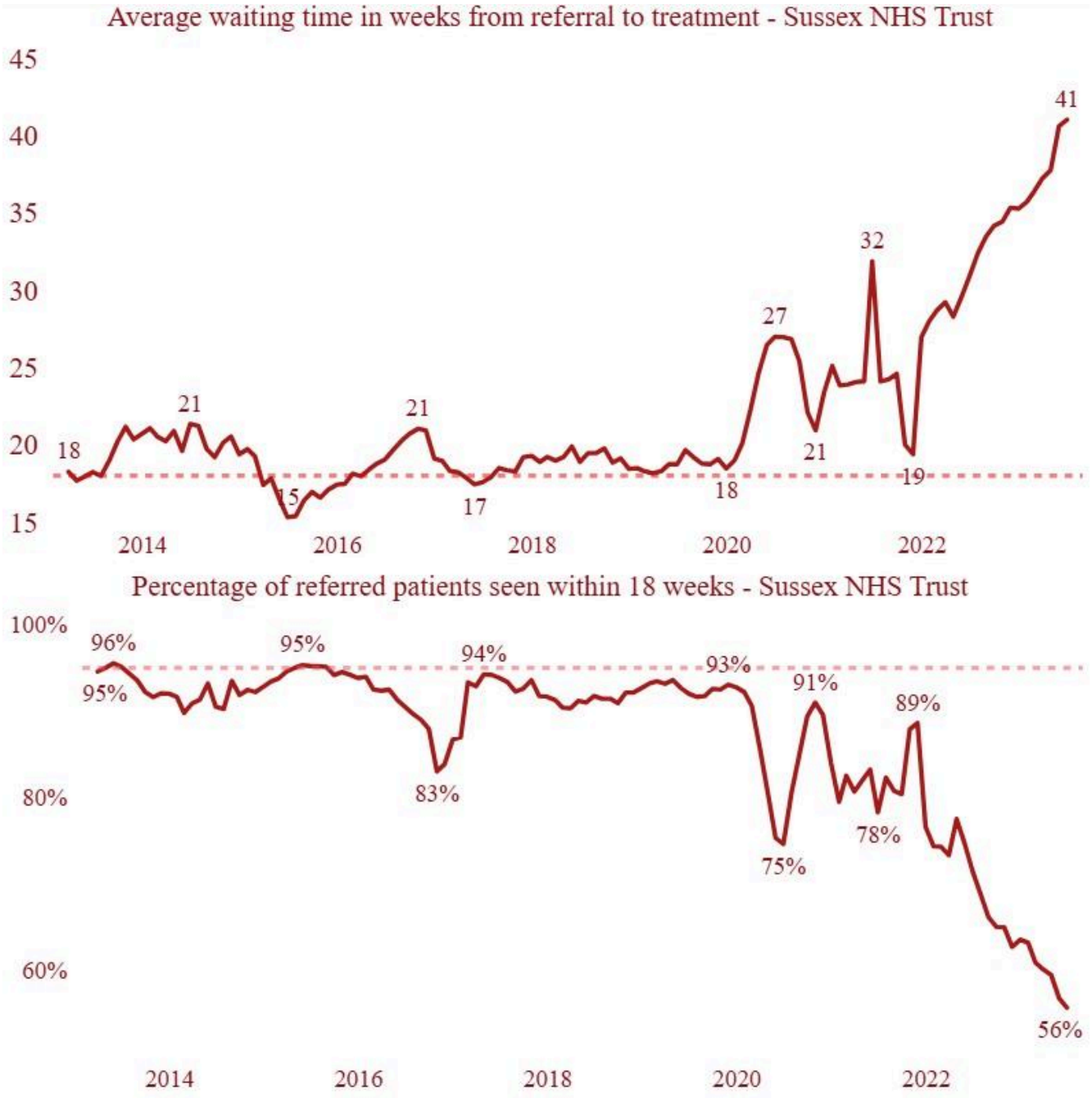


Figure 6.7: Average waiting times and proportion of patients seen within 18 weeks for the Sussex NHS Trust, 2014 - 2023. Source: NHS England data.

The backlog:

All these delays have had profound consequences on the Trust's ability to deliver services. These delays have also created a bottleneck across the NHS, where treatment cannot be delivered, but more cases naturally develop. According to NHS Sussex, the treatment backlog at the start of 2024 reached 63,000[71]. Again, the pandemic has clearly rapidly increased the backlog, with

cases rising from 23,000 to 63,000. Delayed treatment, new illnesses generated from the pandemic and lockdown taking its toll on people's health, have extended demand and the backlog. Yet, even before the pandemic, the backlog was large. From 2016 to 2019, the backlog of cases in the Sussex NHS Trust stood at around 30,000. In 2012, it was only 10,000 cases, See Figure 6.8. This gradual growth in backlogged cases shows the pressure the NHS trust was experiencing before the pandemic. Further, it highlights how even once the pandemic backlog is cleared, the trust will still likely face a large backlog of cases. This is incredibly important as it will be hard to address the challenges discussed throughout this chapter without significantly reducing the backlog. This is because it will be very difficult to meet rising demand until the NHS can deal with its current workload. It will also mean cases will experience lengthy delays and the caseload professionals experience will become more complex, problematic and expensive to treat. This will continue to put strain on staff, further increasing the problem of staff leaving the NHS to work elsewhere. This will only worsen the problem of a high staff-to-patient ratio, making it harder to meet the increasing demand that an ageing population will bring. Yes, more staff can be found, but as we shall next discuss, it is not as easy to do this as it sounds.

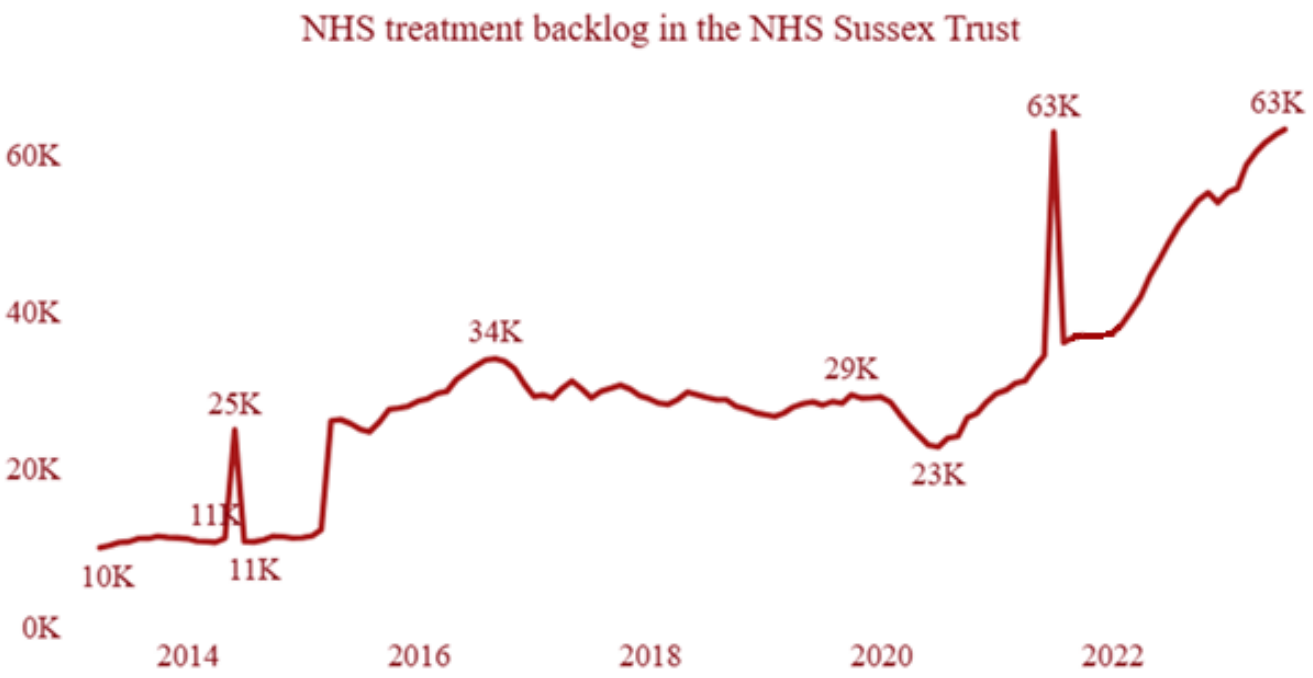


Figure 6.8: NHS treatment backlog, 2014 - 2023 - Sussex NHS Trust. Source: NHS England Data.

Staffing challenges – vacancies and working environment:

Therefore, to tackle the large backlog problem, more staff will be needed. Yet, the vacancy rate remains high, meaning that new staff can't easily be found, despite NHS advertising, government pressure and media focus on the issue. In 2016, there were 2,100 NHS vacancies within the South East region. In 2023, there were 3,500[72]. Specifically, within East Sussex, there is a vacancy rate of 8%[73], again higher than the national average of 6.7%[74]. Also, the vacancy rate for nurses within Sussex was 10.8%, again higher than the 8.7% national average[75]. One reason why Hastings in particular experiences staff shortages is because the town is at the end of a poorly serviced railway line and experiences socio-economic deprivation. This can make it harder to get professionals to move to the area to live and work, especially senior staff (such as consultants) who can shop around more. This high number of vacancies has increased the reliance on agency staff. Spending on Agency staff in 2023 within the East Sussex NHS Trust was £5.3m, a sign that agencies are exploiting the broken staffing structure. The most expensive doctor had a £1,473 hourly rate, and the most expensive nurse had a £661 hourly rate[76]. Additionally, the pandemic and added pressures on staff have increased the number of staff off sick. In July 2023, the Sussex NHS Trust lost 1,200 full-time work days due to staff sickness, 5% of all work days[77]. This again has increased the reliance on agency staff, meaning delays are not addressed, whilst staff costs also rise. This only takes resources away from giving needed treatment and dealing with the trust's problems.

This raises the difficult topic of immigration. Currently, 25% of the Sussex NHS trust's workforce can be categorised as migrant labour coming from overseas[78]. Nationally, it is 17%[79]. Yet, for nurses, this is much higher, at 27%[80]. Further, this is a trend that has been growing. Within the South East, in 2020, only 18% of the workforce was classed as coming from overseas. Yet, in 2024, this rose to 28% of the workforce[81]. This means that the NHS is

currently reliant on immigration for its overall operation and will likely be reliant on such labour to fill vacancies.

One reason for this might be that there is a perception that the NHS is not a desirable place to work. In a yearly survey, staff are asked to grade the trust and their working environment on a series of feelings on a 0 – 10 scale. Nationally, average scores for feeling safe and healthy in their working environment are low, scoring 6.09. Yet, in Sussex, they are even lower, scoring 5.85[82]. A key driver of this score is due to a higher-than-average proportion of staff citing that they were experiencing burnout. This, in part, is likely because a greater proportion of staff report they feel worn out in every day of work, something that worsens staff health and increases turnover. It is troubling that such feelings have been on the rise, with there being a 0.2 increase on the scale of staff feeling burned out from 2021 to 2023[83]. Also, reporting of negative experiences whilst at work and general concerns over health and safety practices created disproportionate concerns of feeling unsafe at work. In both these measures, the Sussex NHS Trust scored 0.2 lower than the national average. Within Sussex, those having negative experiences at work have increased by 0.2 from 2021 to 2023[84]. Again, this indicates that the problem with the NHS staff has been increasing gradually for a number of years, with the pandemic likely reinforcing such trends.

Additionally, scores regarding feelings of having a voice that count were also lower than the national average. The Sussex NHS Trust only scored 6.48, whilst the national score 6.70[85]. This scoring is mainly reached because fewer staff in the Sussex NHS Trust feel that they have autonomy and control over their work and believe they will be able to effectively raise concerns.

Staff morale is also reported to be lower. Nationally, staff score their morale 5.91 (on a 10-point scale). Yet, Staff employed by the Sussex NHS trust only reported an overall score of 5.69[86]. The key driver of these low scores are concerns about work pressure, with the Sussex Trust scoring 0.43 points below the national average. Indeed, the overall national score of 5.31 shows the huge strain all staff in the NHS face on a regular basis. This is something

that has likely worsened in recent years, with such feelings having increased by 0.4 (on a 10–point scale) since 2022[87]. Lower morale also partly stemmed from a greater proportion of staff feeling stressed at work and having thoughts about leaving. Staff in the Sussex NHS Trust also less frequently feel recognised and rewarded, only scoring 5.75 out of 10, below the national average of 5.94[88]. Worryingly, this specific trend has been static for the years the survey has been conducted, indicating poor morale amongst Sussex NHS staff is a long-term problem. This is problematic as these trends have led to a high attrition rate. This is making it impossible to secure the staff needed to manage current health needs, never mind meeting the rising demand that is coming down the line.

Improving Health:

According to campaigners with extensive experience working in the Sussex NHS Trust, the main way to improve the trust's performance is to improve public health. Due to genetics, some illnesses are unavoidable, but such diseases only account for 20% of current health demands[89]. The vast majority of diseases are caused by a combination of social deprivation, nutrition and sedentary lifestyles. Whilst such factors do not cause illnesses as quickly and obviously as other factors (such as accidents and genetics), these problems accumulate, and often materialise in older age. Increasing activity to 150 minutes per week (around 20 minutes per day) can cut dementia, stroke, diabetes and lung disease instances by 30%[90]. It also cuts cancers and injuries related to falls by 40% and heart disease, high blood pressure and osteoporosis rates by 50%. It also decreases intensive care admissions by 45% and the number of operations required by 45%[91]. Further, those who are more mobile tend to have fewer complications when they require surgery, decreasing 55%, with those less mobile 4 times more likely[92]. Due to fewer people needing surgery and experiencing medical complications following treatment, such people are helping to reduce backlogs. They also do not require longer hospital stays as they can recover more quickly and get better at home more often[93]. This is because people older in age who regularly

exercise tend to have stronger muscles and can get themselves out of bed, helping with recovery. This reduces pressure on hospitals by decreasing "bed blocking" and social care services by lowering the number of people requiring longer forms of support. As already mentioned, ESCC spends 50% of its budget on social care and NHS budgets are mostly occupied by those requiring longer intervention[94]. Therefore, reducing the number of people, especially in older age, who need such interventions is a long-term method of reducing the severe financial strain public services are under. It would also reduce caseloads, helping to reduce the proportion of staff who are overworked and experience burnout, potentially easing the recruitment problems identified earlier[95]. Improving nutrition would also reduce obesity rates, something that is also increasing the cost to NHS budgets.

Yet, it must be noted that the problem with these longer-term solutions is that many public health policy interventions trying to improve activity and nutrition have been found to have made no difference[96]. This is partly due to 62% of people feeling it is too dangerous to cycle, and 31% of those over 65 saying they do not walk frequently due to poor paving[97]. Further, a lack of maintained play areas and sports facilities within the Hastings area is deterring activity. As rates of inactivity and poor nutrition remain problematic, and in some cases are worsening, this means that reversing such trends may not be possible, as ultimately it requires individual action beyond the authority of government. Further, poverty rates are also highly associated with such trends and poor health outcomes, with people in the most deprived areas living 11 years longer with poor health than in more affluent areas. As Chapter 9 explains, such rates are worsening[98]. Tackling poverty will not be easy in an era of less money, meaning the NHS will likely need to be prepared for rising health demands. This book now focuses on such policy solutions.

Policy solutions – Improving the Sussex NHS Trust

To address the challenges discussed, a government could do the following:

Overall health:

- Reduce health inequalities. This could be done by pushing funding to more deprived areas.
- Address income inequality.
- Improve food quality, especially at the lower end of the market.
- Helping patients with weight loss and, when required, provide medical intervention (such as weight loss drugs).
- Reduce drug consumption (alcohol, smoking and illegal drug use). This could be done by teaching this subject more widely in schools and investing in drug prevention programmes. This approach is about tackling risk factors.
- Increase the number of people who engage in sport and physical activity on a regular basis.
- Set clear public health goals, giving a clear benchmark that can identify clear improvements in public health. Yet, it must be noted that it is hard to shift averages on such measures.
- Improve cycling routes, public walkways and local sport facilities to encourage greater levels of physical activity.
- Improve early diagnostics, focusing on areas that are most affected by low and declining life expectancies. This will help to reduce early and preventable deaths.
- Invest in health technology and innovation to improve health outcomes.

GP surgeries

- Address the funding model so GP practices can afford to hire more GPs.
- Start training more GPs to meet the rising health demands of the future.
- Introduce incentives for the staff to stay in the profession and measures to reduce burnout, such as higher pay and holiday.

- Direct more funding to coastal communities, where demand for health services tends to be higher.
- Develop a plan to train and hire more GPs in the future to ensure the anticipated rising demand can be met.
- Change the booking system so people can be given a GP within a targeted time, such as a maximum of five days (one working week) wait.
- Ring-fence the GP budget to ensure the money is directed towards the parts of the NHS that can best manage rising demand.
- Ensure that GPs' workloads do not reach above a maximum acceptable limit. This could be done by reforming the GP working model.
- Ensure that GPs' caseloads do not get consumed with very complex, hard-to-manage cases, to help reduce burnout.

Mental Health:

- Train more mental health practitioners.
- Introduce incentives for staff to stay in the profession and measures to reduce burnout, such as higher pay and holiday.
- Prioritise mental health care from those working in the NHS to help reduce staff burnout and turnover.
- Reintroduce more localised services, reducing centralised decision-making.
- Join mental health provision with other NHS services.
- Improve mental health facilities within hospital wards.
- Increase the number of beds and units specifically for mental health patients. This could be achieved by increasing investment to G7 standards.
- Implement the suggested changes coroners' reports have outlined to help avoid future fatalities.
- Increase and ring-fence budgets to help cope with rising demand.

- Increase salaries within coastal communities to incentivise professionals to move to the coast, thus directing skills to where demand is rising most.
- Provide greater mental health training in institutions where mental health patients are likely to be present.

Hospitals

- Increase the number of hospital beds.
- Reform social care provision to help reduce the number of hospital beds taken up by social care patients.
- Increase ambulance capacity.
- Provide greater training to staff on ambulance-to-hospital handovers. This should help to reduce handover times.
- Reduce handover times by changing the location of handovers for patients admitted to hospital, such as handing over once the patient is allocated a bed.
- Provide incentives for staff to stay in the NHS, such as improving pay, increasing annual leave and giving NHS staff priority in healthcare.
- Introduce measures to improve safety.
- Joining health with social care. Specifically, improve coordination between acute hospitals, community services, and social care.
- Using data to improve care, such as using data for real-time decision-making.
- Introduce same-day emergency care. This would help to reduce the number of overnight stays.
- Implement a “Home First” approach, where patients are supported to leave hospital for appropriate care settings, with faster access to required home-based support.

Waiting lists and backlogs

- Expand surgical hubs. This will help increase surgery capacity.

- Increase funding in areas where backlogged cases are high. This will help to divert resources towards surgery.
- Increase capacity to carry out treatment, such as providing needed additional beds and equipment.
- Improve diagnostic capabilities. This will help to catch health problems early and reduce the amount of required invasive treatments.
- Use new technology, such as AI, to identify and reduce bottlenecks.
- Get GPs to work with specialists so to treat patients in primary care and avoid patients being referred to treatment centres that have a large backlog.
- Return to a clear standard waiting time, so to provide a benchmark that can identify when the backlogs have been cleared to an acceptable standard.

Staff

- Improve pay to create a recruitment pull factor towards the NHS.
- Introduce more support for staff to help decrease the high attrition rate. This could include better healthcare for staff and more annual leave.
- Improve and expand training programmes, so to provide more staff for the NHS in future. This will also help meet the anticipated rising demand.
- Improve working conditions, such as safety, to improve retention.
- Improve management of staff to help improve staff recruitment and retention.
- Deal with pension problems and improve the pension offer to NHS staff.

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[87] Sussex Trust Staff Survey results, 2023. Available at: https://cms.nhsstaffsurveys.com/app/reports/2023/RYR-benchmark-2023.pdf - Page 84.

[88] Sussex Trust Staff Survey results, 2023. Available at: https://cms.nhsstaffsurveys.com/app/reports/2023/RYR-benchmark-2023.pdf - Page 12.

[89] Information gathered by a presentation delivered by a surgeon from the Sussex NHS Trust, who campaigns for better public health.

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[94] Information gathered by a presentation delivered by a surgeon from the Sussex NHS Trust, who campaigns for better public health.

[95] Information gathered by a presentation delivered by a surgeon from the Sussex NHS Trust, who campaigns for better public health.

[96] A BBC article outlining how public health campaigns have had mixed outcomes, with some generating no obvious benefits.
https://www.bbc.co.uk/news/health-46097028

[97] Information gathered by a presentation delivered by a surgeon from the Sussex NHS Trust, who campaigns for better public health.

[98] Information gathered by a presentation delivered by a surgeon from the Sussex NHS Trust, who campaigns for better public health.