Appendix 'F'

Securing our Health and Wellbeing

Report of the Director of Public Health and Wellbeing 2016

Lancashire County Council

www.lancashire.gov.uk

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Contents

Preface

It is a well-known fact that Lancashire is the birthplace of the industrial revolution that began in the 18th Century. Our ancestors include some of the most hardworking and innovative people in the world. We have a rich and diverse heritage, culture, social capital and assets on which we have built our economy and health.

The responsibilities for protecting and improving the public's health were transferred back to Lancashire County Council in 2013. This means the public health functions have come home to the local government, since they left in 1974. Local government has an opportunity to embed public health objectives in everything it does – to address not just ill health prevention and influence the NHS but also promote what determines good health and wellbeing – education, skills, jobs, homes, healthy environments, transport, to name a few. We have already seen some success stories. For example, all the play areas in Lancashire have become smoke free in 2016 and there are many similar exemplars of good practice.

At the same time, there are new challenges. Our county is ageing and the burden of disease is on the rise. The economic downturn at the beginning of this century, the political choices being made by the UK government in allocating the scarce public resources to address the structural deficit in our economy, and the impact this could have on our lives, and on the sustainability of public services including the NHS is a key concern.

Traditionally, the Directors of Public Health report progress on the recommendations made in their previous reports. As this is my first report covering 2013 – 2015, I have described what determines our health and wellbeing and made recommendations to protect and improve it. **I hope to draw your attention on three main issues – we have been adding years to our lives but not necessarily life to our years; addressing health inequalities needs action across the social gradient within our county and not just in the most deprived communities; and that protecting and promoting good health is not just a social issue but also crucial for our local and national economy.**

It is common knowledge that the financial resources within the public

sector, both nationally and within our county are not going to increase to meet the needs and demands of our changing demography. Having the focus on financial savings alone can distract organisations from improving health and wellbeing. Therefore, we need to relentlessly pursue the 'Triple Aim' of improving outcomes, enhancing quality of care and reducing costs at the heart of everything we do.

In order to pursue the 'Triple Aim' in our county, we need a strong and longer term political will to radically upgrade our efforts on prevention; we need fully engaged individuals, families, communities and businesses in improving wellbeing; and a workforce that embraces innovation and puts people and the places they live at the centre of everything they do. This report focusses on key actions we need to take on these areas.

The last County Medical Officer of Health Dr. Charles Henry Townsend Wade said in his annual report in 1973 "… my grateful thanks to all the staff… who have continued to co-operate in the maintenance and advancement of the various services, whilst undertaking much work involved in the reorganisation". I'd like to echo his words and add that I am proud and privileged to be working with so many motivated and inspiring individuals across the county – politicians and professionals across various sectors alike.

My vision is to develop Lancashire into a safer, fairer and healthier place for our residents. I invite your feedback, debate, and ideas to shape this further and make the vision into a reality for the current and future generations. Together, let us make Lancashire the birth place for a wellbeing revolution in the 21st Century.

Yours sincerely,

Dr. Sakthi Karunanithi MBBS MD MPH FFPH
Director of Public Health and Wellbeing

1 About Lancashire

Lancashire has an estimated population of 1.18 million spread over 2,900 km^2. The average population density (people per km^2) is 408, compared to the North West average of 506 and an England and Wales average of 380[1].

The population is projected to increase 5.8% by 2037, with the number expected to reach 1.24 million. The estimated increases are lower than the average for the North West (7.9%) as a whole, and well below the expected increase for England of 16.2%.

At the district level, Hyndburn and Burnley are actually predicted to see small population decreases between 2012 and 2037, whilst Rossendale and Chorley are the only Lancashire authorities with projected increases in excess of 10%.

Analysis by age reveals that most of the age-groups between 0 and 64 years are predicted to decrease between 2012 and 2037. A substantial increase of over 50% is predicted in the over 65 age group. The number of people aged 90 years and older is projected to increase from around 10,000 in 2012 to around 32,000 in 2037[2].

2011 census showed that the largest ethnic group is white (90%). The black and minority ethnic group (BME) makes up 8% of the population, the majority of this group were Asian/Asian British. Numerically, there were over 90,000 black minority ethnic people in the county. Three-quarters of the BME population reside in Preston, Pendle, Burnley and Hyndburn. Across England and Wales, the white population accounted for 86% and BME accounted for 14%.

There are wide variations in levels of income, wealth and health across the county. In more rural areas social exclusion exists side-by-side with affluence and a high quality of life. Several districts have small pockets of deprivation, but there are also larger areas of deprivation, particularly in east Lancashire, Morecambe, Skelmersdale and parts of Preston.

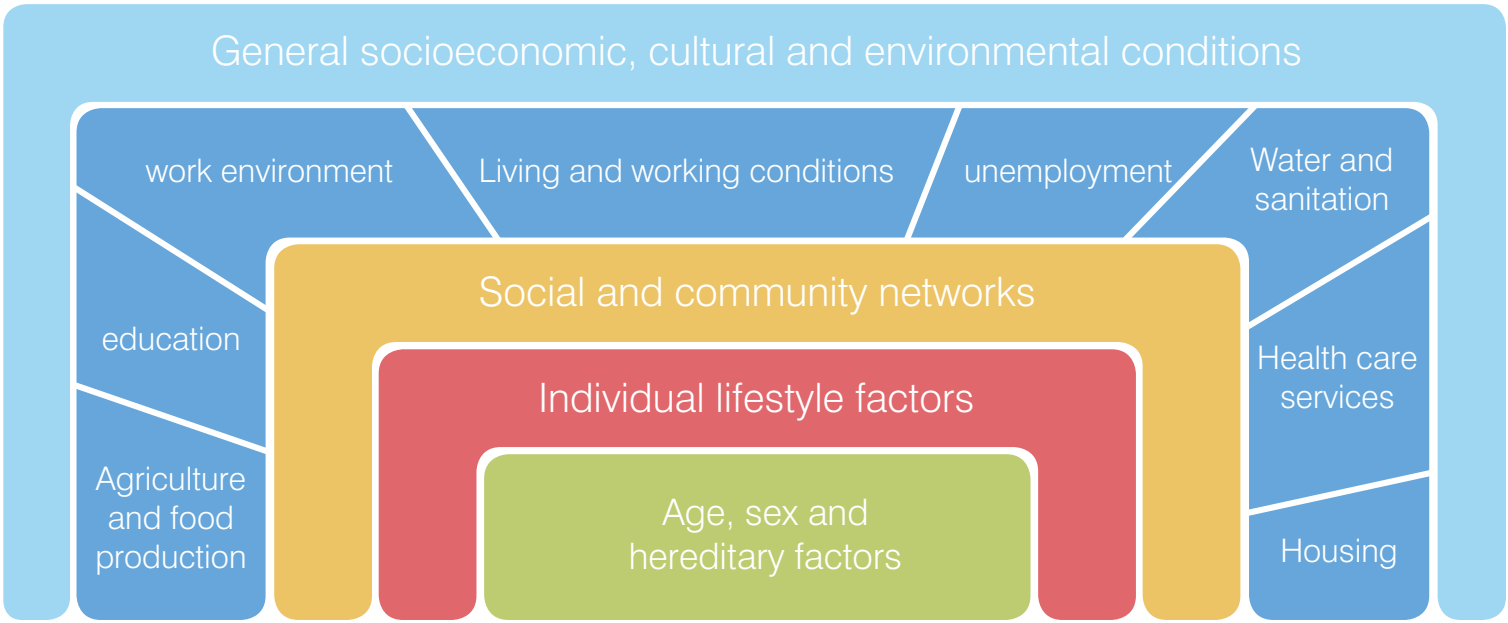
Further details of the demography and population projections can be accessed by clicking on Lancashire Insight - www.lancashire.gov.uk/lancashire-insight.aspx

Lancashire county has 12 district councils and neighbours the two unitary authorities of Blackpool and Blackburn with Darwen. There are six NHS clinical commissioning groups (CCGs) in the council area with one in each of the unitary councils. Lancashire is also served by five key NHS Trusts, over 250 GP practices and a similar number of pharmacies and a wide range of social care providers. A single fire and rescue service, constabulary and police and crime commissioner cover the whole of Lancashire. Key strategic partnerships in the county council area include a Health and Wellbeing board, a Children and Young People Trust Board, a Safeguarding Adults Board, a Safeguarding Children Board, and a Lancashire Enterprise Partnership. There are three main university campuses in the county and specialist agriculture and maritime college facilities.

1 ONS, Mid-2014 Population Estimates
2 ONS, 2012-based Sub-National Population Projections

2 The state of our health and wellbeing

Our health and wellbeing is determined not only by the quality of health and care services and lifestyle factors but also by a range of good health promoting factors including the conditions in which we are born, live and work – which are referred to as the socioeconomic and environmental determinants (SEEDs) or root causes of health. An illustration of the determinants of health by Dahlgren and Whitehead (1992) is provided below. Therefore, it is all these determinants that we need to act on to improve our health and wellbeing. Many of these are influenced by local and national government policies and programmes and not just by the NHS.



The Determinants of Health (1992) Dahlgren and Whitehead

An analysis of key measures of health and wellbeing and its determinants are presented in this report.

2.1 Life Expectancy and Healthy Life Expectancy

Life Expectancy (LE) and Healthy Life Expectancy (HLE) are well known global measures of health and wellbeing. The slope index of inequality in life expectancy and healthy life expectancy is a measure of variation between most deprived and least deprived areas.

The table below shows the female and male LE and HLE in Lancashire.

In summary, the life expectancy at birth for both females and males have been increasing over the years. However, there is a gap of 7.1 and 10.2 years between our least and most deprived areas for females and males respectively.

The gap between the female LE and the national average has also widened. None of the districts are significantly better than the national average. South Ribble, Ribble Valley, West Lancashire, and Fylde are similar to the national average and the rest are significantly worse than national average.

Male LE in Fylde, West Lancashire, and Chorley is similar to the national average. While South Ribble and Ribble Valley have better male LE than the national average, the rest of the districts have significantly worse male LE than the national average.

The average number of years a female child can expect to live in good health, otherwise called healthy life expectancy, is 62.4 years, meaning they will spend 19.7 years in not so good health.
The average number of years a male child can expect to live in good health, otherwise called healthy life expectancy, is 61.3 years, meaning they will spend 17.2 years in not so good health. HLE has been decreasing since 2009. It is significantly worse than England average.

	Female	Male
Life expectancy at birth in years (Lancashire)	82.1	78.5
Life expectancy at birth (England)	83.2	79.5
Gap between most and least deprived MSOAs in Lancashire	7.1	10.2
Healthy life expectancy at birth (HLE) in Lancashire	62.4	61.3
Healthy life expectancy at birth in England	63.9	63.3
Gap in HLE between most and least deprived MSOAs in Lancashire	15.6	15.8

We have been adding years to our lives but not necessarily life to our years. Healthy life expectancy in males has decreased since 2009. If not addressed, this is likely to affect the economy and productivity of our workforce.

2.2 Social, Economic, Environmental Determinants (SEEDs) of Health and Wellbeing

An independent review, led by Sir Michael Marmot examined the most effective evidence-based strategies for reducing health inequalities in England. The final report, 'Fair Society Healthy Lives', was published in February 2010, and concluded that reducing health inequalities would require action on six policy objectives:

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

A framework of indicators, called Marmot Indicators, are published regularly for Local Authorities in England. Analysis of data published in December 2015[3] has identified that Lancashire is significantly better than the national average in the following areas:

- Good level of development at age 5 (%)
- Good level of development at age 5 with free school meal status (%)
- Long term claimants of Jobseeker's Allowance (rate per 1,000 population).

The analysis also identified that Lancashire is significantly worse than the national average in the following areas:

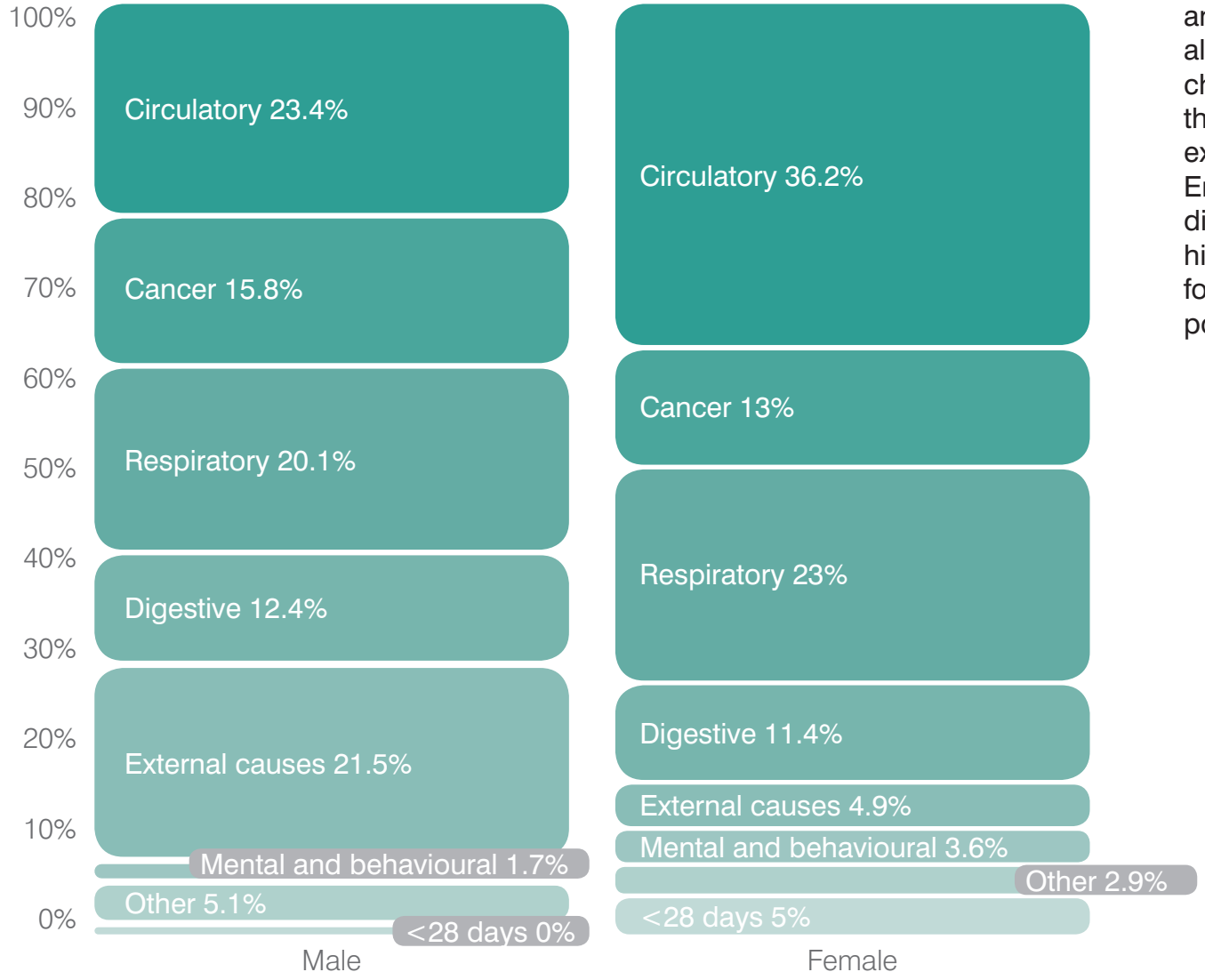
- Life expectancy and healthy life expectancy for females and males
- GCSE achieved 5A*-C including English & Maths with free school meal status (%)
- Fuel poverty for high fuel cost households (%).

It should be noted there is a significant variation between the districts within Lancashire. Any action to address the SEEDS of wellbeing need to focus on the areas that need the most support as well as improving them across the whole of Lancashire.

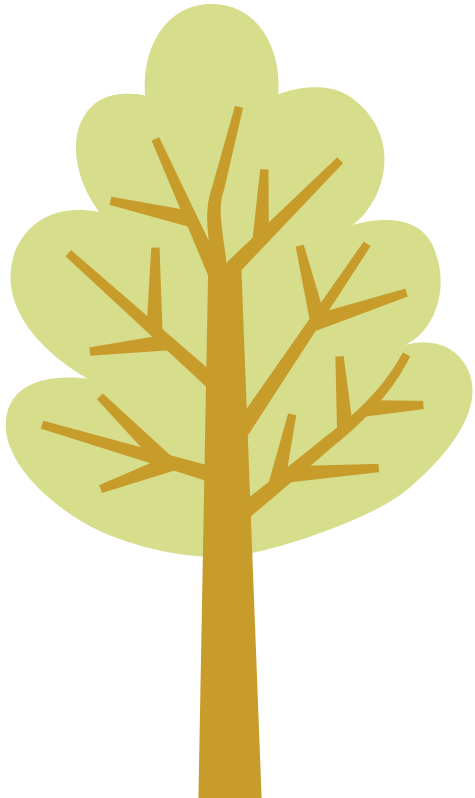
Analysis of causes of excess deaths (The Segment Tool) has been developed by Public Health England (PHE) to provide information on the causes of death that are driving inequalities in life expectancy at local area level. Targeting the causes of death which contribute most to the life expectancy gap should have the biggest impact on reducing inequalities. The following chart provides further information on the causes of death that are driving inequalities in life expectancy at Lancashire level. The tool also allows analysis at a district level.[4]

3 https://neighbourhood.statistics.gov.uk/HTMLDocs/nessgeography/superoutputareasexplained/output-areas-explained.htm
4 https://www.gov.uk/government/statistics/english-indices-of-deprivation-2015

Chart showing the breakdown of the life expectancy gap between Lancashire as a whole and England as a whole, by broad cause of death, 2010-2012



The chart shows that circulatory diseases (includes coronary heart disease and stroke), cancer, respiratory and digestive diseases (includes alcohol-related conditions such as chronic liver disease and cirrhosis) are the major reasons for the gap in life expectancy between Lancashire and England. Of particular concern is the difference in gap caused by significantly higher proportion of external causes for men (include deaths from injury, poisoning and suicide).



The Table below shows further breakdown of the life expectancy gap between Lancashire as a whole and England as a whole, by broad cause of death, 2010-2012.

	Male			Female		
Broad cause of death	**Number of deaths in local authority**	**Number of excess deaths in local authority**	**Contribution to the gap (%)**	**Number of deaths in local authority**	**Number of excess deaths in local authority**	**Contribution to the gap (%)**
Circulatory	5,044	364	23.4	5,444	637	36.2
Cancer	5,183	211	15.8	4,533	80	13.0
Respiratory	2,492	334	20.1	2,819	385	23.0
Digestive	918	134	12.4	985	131	11.4
External causes	829	128	21.5	466	17	4.9
Mental and behavioural	880	23	1.7	1,875	74	3.6
Other	1,430	-69	5.1	2,101	-40	2.9
Deaths under 28 days	68	-2	..	65	12	5.0
Total	**16,844**	**1,124**	**100**	**18,289**	**1,296**	**100**

This means there were at least 2420 excess deaths in Lancashire between 2010 and 2012 compared to England average.

2.3 Analysis of inequalities within Lancashire[5]

Further local analysis of the inequalities within Lancashire is aimed to target specific actions in the areas causing the most inequalities. The table below describes the ten worst health inequalities in Lancashire.

	The ten worst inequalities in health outcomes	
1	Diabetes	Those in the most deprived areas are over seven times as likely to die prematurely from diabetes as those in the least deprived areas.
2	Respiratory disease	Those in the most deprived areas are over four and a half times as likely to die prematurely from chronic obstructive pulmonary disease as those in the least deprived areas.
3	Digestive disease	Those in the most deprived areas are over three times as likely to die prematurely from chronic liver disease as those in the least deprived areas.
4	Mental health problems	Those in the most deprived areas are three times as likely to suffer from extreme anxiety and depression as those in the least deprived areas.
5	Lung cancer	Those in the most deprived areas are over two and a half times as likely to die prematurely from lung cancer as those in the least deprived areas.
6	Circulatory disease	Those in the most deprived areas are over two and a half times as likely to die prematurely from coronary heart disease, and over twice as likely to die prematurely from stroke as those in the least deprived areas.
7	Accidents	Those in the most deprived areas are over twice as likely to die prematurely as a result of an accident as those in the least deprived areas.
8	Quality of life	Those in the most deprived areas are over twice as likely to experience extreme pain and discomfort and over one and a half times as likely to have problems with mobility, self-care and performing usual activities as those in the least deprived areas.
9	Unplanned hospital admissions	Those in the most deprived areas are over one and a half times as likely to be admitted to hospital in an emergency as those in the least deprived areas Those in the most deprived areas are over one and a half times as likely to be admitted to hospital in an emergency as those in the least deprived areas.
10	Narrow the gap in infant mortality	In the most deprived areas, babies up to one year old are over one and a half times as likely to die as those in the least deprived areas.

5 Based on new health inequalities analysis JSNA 2014. http://www3.lancashire.gov.uk/corporate/web/?siteid=6117&pageid=35405&e=e

2.4 Economy, Ill Health, Disability and State Pension Age

It is estimated that more than 130 million days are still being lost to sickness absence every year in Great Britain and working-age ill health costs the national economy £100 billion a year[6]. This is greater than the annual budget for the NHS in 2013/14 and comparable to the entire GDP of Portugal. The costs to the taxpayer – benefit costs, additional health costs and forgone taxes – are estimated to be over £60 billion.

It is estimated that the state pension age for children born in 2015 will be 68 years. It is therefore important to have as much a healthy and disability free life expectancy as possible during working age and before reaching the state pension age. Using raw data available at middle super output area (MSOA) level, it is estimated that a disability free life expectancy of over 68 years can be achieved in only 18 out of 154 MSOAs for females, and in 12 out of 154 MSOAs for males. This is an important consideration for having a healthy and productive workforce in the future. We need to act now to create the conditions to have healthy working life for our population, particularly for our children.

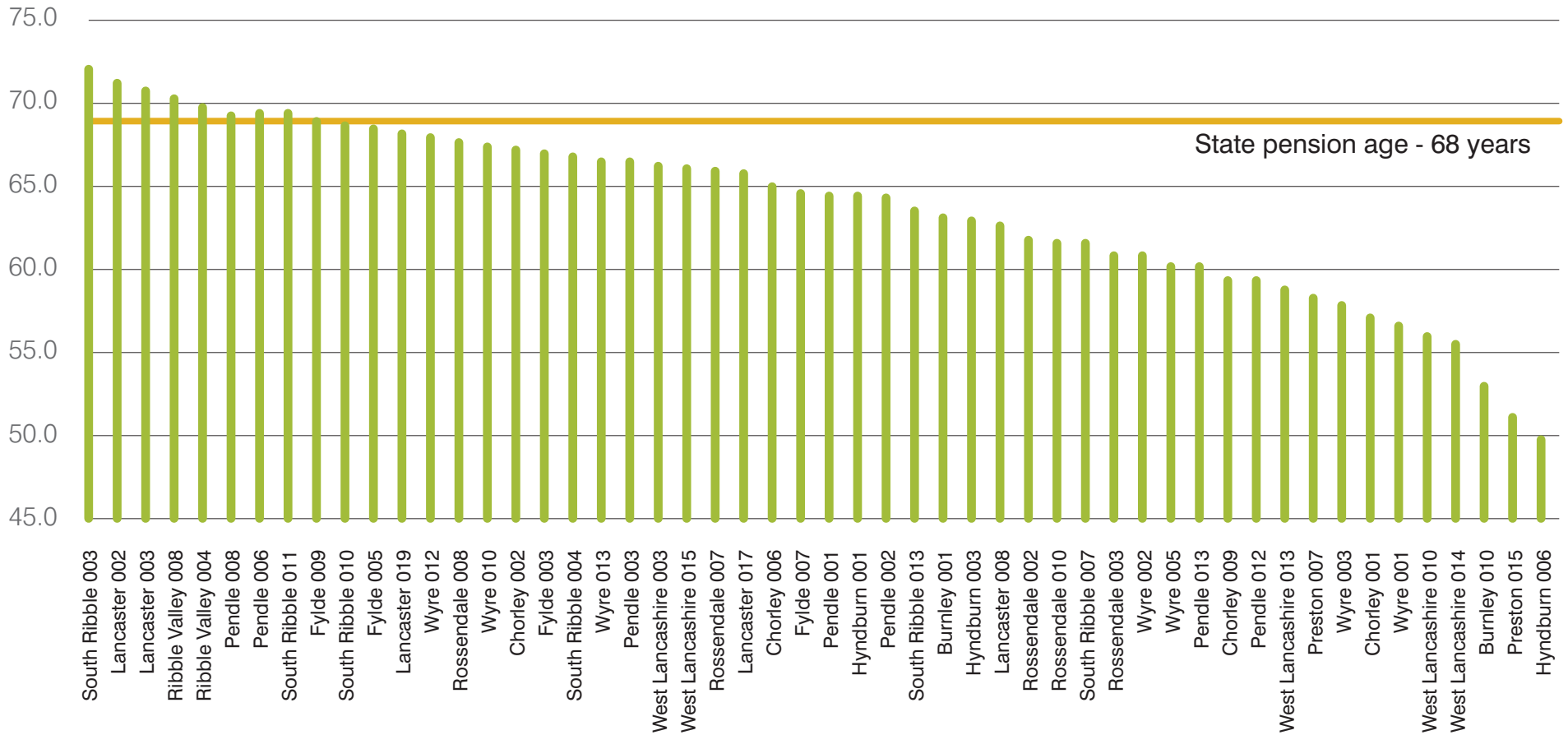
2.5 Inequalities across the social gradient

Another important consideration is that these inequalities are not just present within the most deprived and the rest of Lancashire. There is a gradient across the county based on the indices of deprivation. As an illustration, the bar chart shows the gradient female healthy life expectancy across the 154 MSOAs in Lancashire. Hence, improving the outcomes only in the most deprived areas of Lancashire will not be enough to improve the outcomes across the county. We need a response proportionate to the need in each of these geographical areas. In other words, we need proportionate universalism as described in the Fairer Society, Fairer Lives report by Sir Michael Marmot.

These inequalities are not just between the most deprived areas and the rest. In fact they exist across our social gradient. We need to up our game across all sections of our society.

6 https://www.gov.uk/government/news/a-million-workers-off-sick-for-more-than-a-month

Distribution of Female Healthy Life Expectancy across Lancashire



There is a strong commitment to tackle health inequalities in Lancashire. This was demonstrated by the Joint Strategic Needs Assessment of Health Inequalities conducted in 2009 and then repeated in 2014. Analysis of change in the gap show that the gaps in early deaths from diabetes has widened between 2009 and 2012 and the gap in some of the important causes of health inequalities such as income, fuel poverty and drinking alcohol at levels hazardous to health have also widened over the last three years. On the other hand, the gaps in anxiety and depression and early deaths from heart disease and stroke had narrowed; with rates in the most deprived parts of the population improving faster than the least deprived. This shows that it is possible to narrow the health gap with concerted co-ordinated efforts across partner organisations.

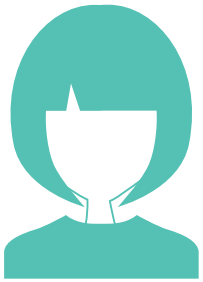
In addition, The Lancashire Fairness Commission was set up to provide an independent perspective on inequality in Lancashire and to make recommendations to increase fairness to Lancashire County Council and its partners. The commission reported in March 2015 and its recommendations can be found at http://www.lancashire.gov.uk/media/584910/4000-Fairer-Lancashire-Fairer-Lives.pdf

3 Healthier Lifestyles

It is estimated that around 40% of all deaths in England are related to lifestyles. The NHS spends more than £11bn a year on treating illnesses caused by the effects of diet, inactivity, smoking and drinking alcohol.

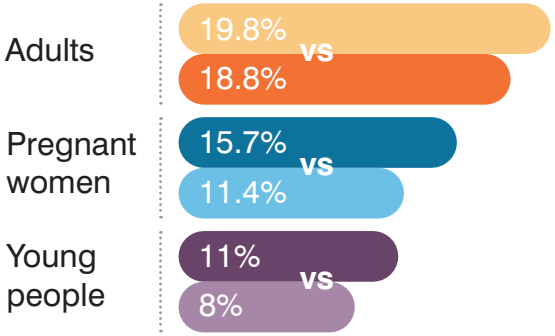
Key facts about lifestyles in Lancashire[7]

3.1 Tobacco



Tobacco smoking kills **1,673** adults aged 35 years and over in Lancashire each year

Smoking rates remain higher in Lancashire than nationally:

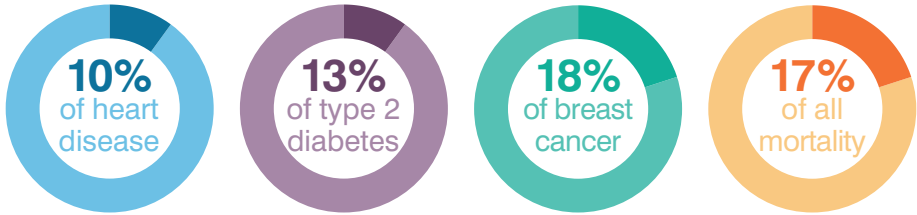


- Cost of smoking to society in Lancashire is £291.7 million each year, including £50 million NHS care
- A smoker of 20 cigarettes a day spends £2,800 a year, family where both parents smoke spend £5,600 a year
- Two-thirds of smokers (63%) want to quit and welcome support to do so.

3.2 Physical activity

Inactivity, described by the DH as a "silent killer," directly costs the NHS across the UK an estimated **£1.06 billion**

Estimates suggest that in England, physical inactivity causes



- Six districts in Lancashire are significantly worse than the national average in terms of children's activity levels (England average 55.13%)
- In Lancashire, at a county level, the level of inactivity is 30.41% in adults.
- This amounts to 284 premature deaths per annum at a cost of £19,937,814.
- This percentage of inactivity in adults is significantly higher than the national average for England.

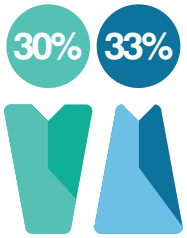
7 Various sources, including www.lancahire.gov.uk/JSNA

3.3 Overweight and Obesity

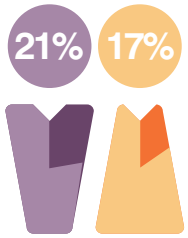
Each year, an estimated **£5.1 billion** is spent on obesity related health problems

- In Lancashire, the percentage of overweight and obese adults is higher than the national average by 0.9% (Lancashire, 64.7% compared to England 63.8%).
- Similarly, the percentage of overweight and obese children in reception (aged 4-5 years) is higher than the national average by 1.3% (Lancashire, 23.5% compared to England 22.2%).

Obesity is known to be related to social disadvantage.

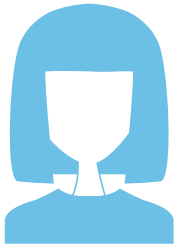


Nationally, around 30% of men and 33% of women with no qualifications are obese...



...compared to 21% of men and 17% of women with a degree or equivalent.

3.4 Alcohol



Alcohol misuse costs **£21 billion** per year in England (Lancashire £495m).

7.8% of Lancashire population are estimated to be high risk drinkers

24% are estimated to be binge drinking

4% are dependent

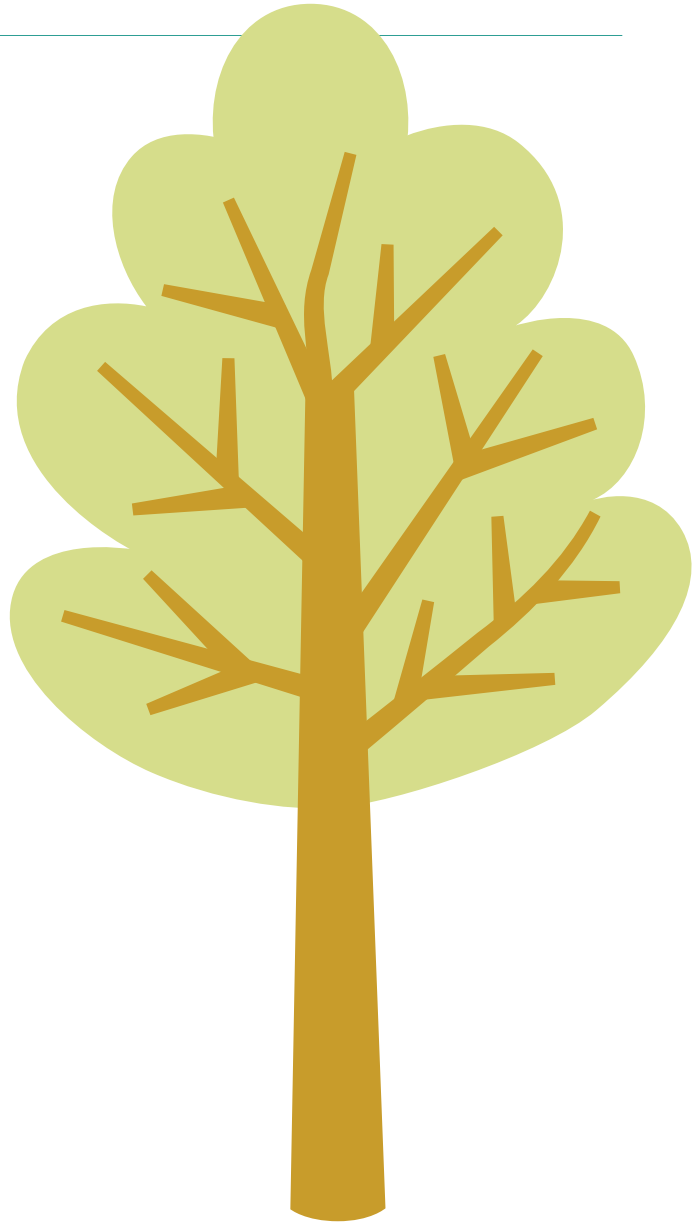
21.3% have increasing risk due to alcohol misuse

4 Economic case for prevention and early intervention

The National Institute for Health and Care Excellence (NICE) has examined the costs of ill health and advices that public health activities do save money by preventing premature death and reducing preventable diseases can boost the economy.

CIPFA estimates that £1 spent on prevention leads to savings of £5-6 to the public purse. It argues that this kind of "public pound multiplier" is due to the relatively inexpensive interventions that can mitigate the spiralling costs of acute care down the line. If this could be replicated throughout the NHS, the health service would eventually see a reduction in financial pressure.

Another study done by the Early Intervention Foundation shows that picking up the pieces from damaging social problems affecting young people such as mental health problems, going into care, unemployment and youth crime costs the Government almost £17 billion a year[8]. Their analysis finds that almost a third of this bill came from the annual £5 billion cost of looking after children in care. An estimated further £4 billion a year is spent on benefits for 18-24 year-olds not in education, employment or training (NEET) with another £900 million spent helping young people suffering from mental health issues or battling drug and alcohol problems.



8 http://www.eif.org.uk/publication/spending-on-late-intervention-how-we-can-do-better-for-less/

5 Opportunities for improving quality of care

The variation in quality of care across the NHS and the tools to address them have been published by the NHS Right Care programme. Together with the New Care Models, they are aimed to support the vision set out in the Five Year Forward View[9] with its focus on the transformation of healthcare services to drive improvements in quality and efficiency.

The table provides a list of common areas of improvement across a range of disease pathways in Lancashire. The data packs for individual CCGs in Lancashire can be accessed here: https://www.england.nhs.uk/resources/resources-for-ccgs/comm-for-value/nth-2016/#lan

Disease pathway	Common themes for improvement across Lancashire
Cancer (Breast, Colorectal and Lung)	Breast screening, Bowel Cancer screening, early diagnosis and starting definitive treatment within 2 months.
Diabetes	Control of blood pressure and cholesterol Retinal screening
Common mental health conditions	Improving access to psychological therapy completion and demonstrating reliable improvement
Heart disease	Control of hypertension and high cholesterol
Stroke	Treatment of Transient Ischaemic Attack within 24 hours Patients with stroke spending 90% of the stay in a stroke unit Emergency readmissions within 28 days of discharge
COPD	Improving the identification of people with COPD on GP registers Measuring FEV1 to assess COPD
Asthma	Emergency admissions for children and young people (0-18)
Musculoskeletal	Management of osteoporosis EQ5D health gain for people undergoing hip and knee replacement Emergency readmissions within 28 days of discharge following hip replacement
Trauma	Falls in elderly, emergency readmissions within 28 days of discharge following hip fracture
Renal	Percentage of people with chronic kidney disease on home dialysis Percentage of people with renal replacement therapy who have renal transplant
Maternity and early years	Many areas have worse outcomes e.g. under 18 pregnancy, smoking during pregnancy, breast feeding at 6-8 weeks, childhood obesity at reception age, AE attendances for under 5s

9 https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

5.1 Analysis of resources utilised in managing complex patients

Complex patients are individuals with multiple comorbidities that are likely to utilise most resources across programmes of care and the urgent care system. Understanding them can support local discussions in managing this cohort of the population via integrated care planning and supported self-management arrangements.

Nationally, it is estimated that 2% of patients comprise 15% of spend on inpatient admissions in 2013/14. Nationally the most common conditions of admissions for complex patients are circulation; cancer; and gastro-intestinal problems. Whilst this analysis only focuses on secondary care due to availability of data, it is expected that these patients are fairly representative of the type of complex patients who will require the most treatment across the health and care system. It is not possible to include analysis on mental health patients as they are not captured fully in these datasets.

Other key facts about the complex patients include:

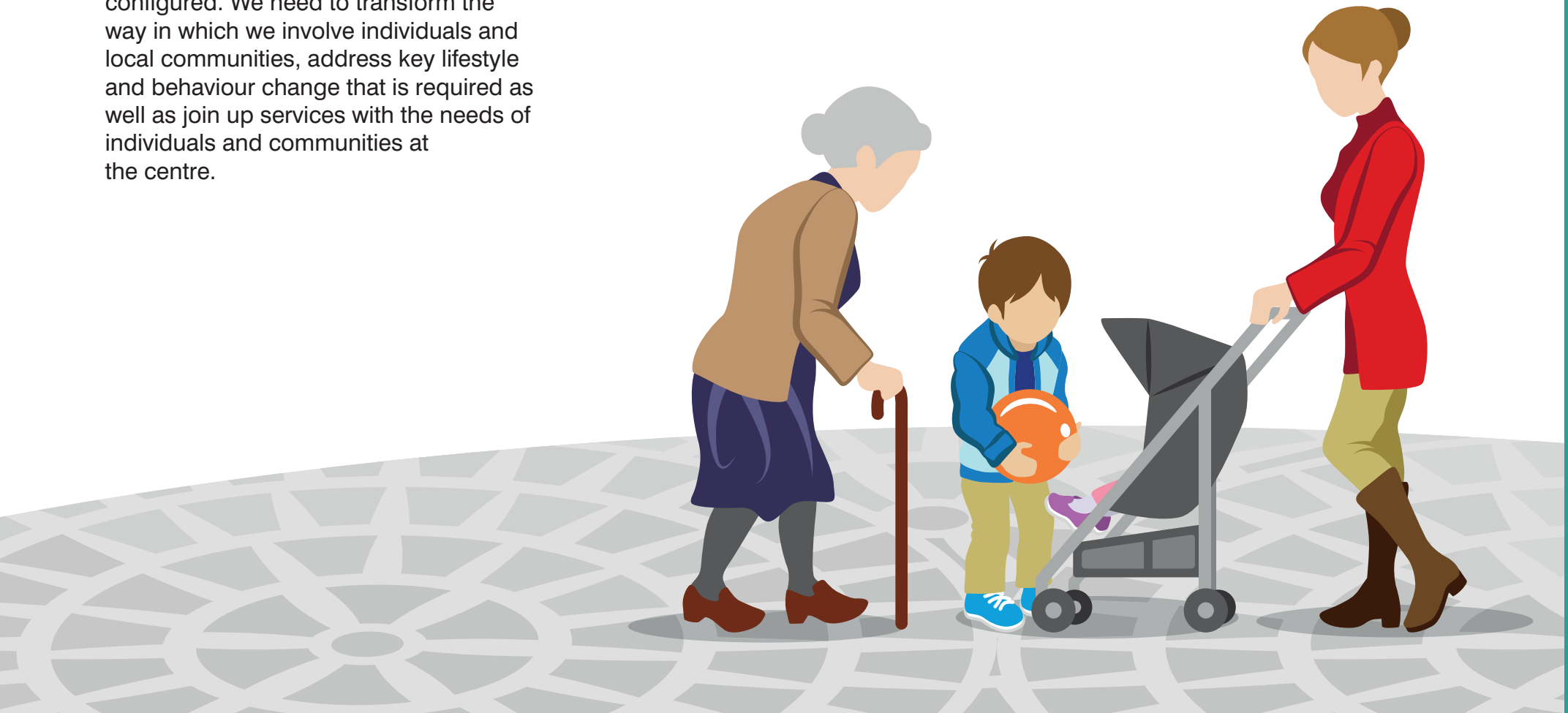
- The average complex patient has 6 admissions per year for three different conditions (based on programme budget categories).
- 59% of these complex patients are aged 65 or over; 37% of these complex patients are aged 75 or over
- 13% of these complex patients are aged 85 or over; 92% of the complex patients also had an outpatient attendance during the year. Those patients had 13 attendances a year on average.
- 81% of the complex patients also had an A&E attendance during the year. Those patients had 4 attendances a year on average.
- The proportion of CCG spend on the 2% of their most complex patients is provided in the table below:

CCG	Number of patients	Proportion of CCG spend on their 2% most complex patients	CCG Spend in £'000
Lancashire North	498	16.5%	10,299
Fylde and Wyre	522	15.6%	10,233
Greater Preston	689	16.4%	13,444
Chorley and South Ribble	589	16.5%	12,167
East Lancashire	1,249	16.8%	25,775
West Lancashire	393	16.4%	7,635
Total	3,940		79,553

6 The funding and efficiency gap

It is estimated that there will be a gap between patient needs and NHS resources of nearly £30 billion a year by 2020/21. In Lancashire, there is an estimated funding gap in excess of £805 million between NHS, adult social care and public health budgets. This gap means that we cannot continue to deliver the services as they are organised and configured. We need to transform the way in which we involve individuals and local communities, address key lifestyle and behaviour change that is required as well as join up services with the needs of individuals and communities at the centre.

The NHS Five Year Forward View focusses on preventing ill health, redesigning more productive services, harnessing innovation and technology, transparency in understanding the spending patterns and maximising the value of the NHS budget as the main ways of closing the funding gap.



7 Strategic Opportunities in Lancashire

In spite of the challenges in outcomes, quality and costs, there are positive developments happening across Lancashire to address these challenges. For example:

The NHS Five Year Forward View and the Sustainability and Transformation planning guidance has put prevention, a place based approach, and integration of health and social care at the centre. This is already emerging in the two Vanguard programmes (Lancashire North and Fylde and Wyre CCG areas) and similar programmes in other local health care economies.

Local Authorities and the wider public sector agencies are working more closely together. The formation of a Combined Authority will enhance the momentum in improving transport, housing and economic regeneration opportunities. This is a significant development towards reducing health inequalities.

Lancashire Constabulary, Office of the Police and Crime Commissioner, Lancashire Fire and Rescue Service, and the Lancashire schools forum have prioritised prevention and early intervention.

There is an enthusiastic VCFS sector and various new business models to mobilise individuals and communities for collective action on health and wellbeing are already emerging e.g. Lancashire time credits programme.

Lancashire County Council has put improving health and life chances of its residents at the heart of its evolving corporate strategy

8 Enabling innovation through our workforce and digital technology

8.1 A 21st Century workforce

As the public services reform and health and care integration takes hold, it is important to consider the skills and attributes of our workforce in Lancashire and beyond. The workforce needs to be enabled to make every contact with our residents count towards their wellbeing. This is particularly relevant for staff working with vulnerable and complex individuals and families where they need to act as the lead professionals. Research conducted by the Birmingham University has identified a series of characteristics which are associated with the 21st Century Public Servant[10].

We need to embrace these attributes when considering our workforce development plans across the public sector.

8.2 The 21st Century Public Servant

1 is a municipal entrepreneur, undertaking a wide range of roles
2 engages with citizens in a way that expresses their shared humanity and pooled expertise
3 is recruited and rewarded for generic skills as well as technical expertise
4 builds a career which is fluid across sectors and services
5 combines an ethos of publicness with an understanding of commerciality
6 is rethinking public services to enable them to survive an era of perma-austerity
7 needs organisations which are fluid and supportive rather than silo-ed and controlling
8 rejects heroic leadership in favour of distributed and collaborative models of leading
9 is rooted in a locality which frames a sense of loyalty and identity

10 http://www.birmingham.ac.uk/Documents/college-social-sciences/public-service-academy/21-century-report-28-10-14.pdf

8.3 Harnessing the power of digital technology

Personalised Health and Care 2020 is a framework for action by the National Information Board to use data and technology to transform outcomes for citizens and patients. It describes that in the airline industry 70% of flights are booked online and 71% of travellers compare more than one website before purchasing. A paper ticket was once a critical 'trusted' travel document, yet today around 95% of tickets are issued digitally as e-tickets. In Britain we use our mobile phones to make 18.6 million banking transactions every week; automation of particular services has helped cut costs by up to 20% and improved customer satisfaction. More than 22 million adults now use online banking as their primary financial service[11].

In 2014 59% of all citizens in the UK have a smartphone and 84% of adults use the internet; however, when asked, only 2% of the population report any digitally enabled transaction with the health and care services. There is also evidence that people will use technology for health and care, given the opportunity. There are 40 million uses of NHS Choices every month, of which some 5 million are views by care professionals who regard this service as a trusted source of information and advice. The internet-based sexual and general health service, Dr Thom (now part of Lloyds online), has seen 350,000 individuals sign up as users.

In Airedale, West Yorkshire, care home residents have quickly embraced an initiative that gives them the opportunity to tele-access clinicians from the local hospital over a secure video link. A reduction in local hospital admissions of more than 45% has been reported among that group of people.

Used appropriately, technology could help transform care via telehealth, telecare, mobile applications and social media, and by timely information sharing between care professionals. NHS FYFV and the Sustainability and Transformation Plan requires each area to develop a digital road map by June 2016.

11 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/384650/NIB_Report.pdf

9 Key actions to secure our health and wellbeing

We need to develop Lancashire as a County of Wellbeing. It involves addressing the wider determinants of health and wellbeing, mobilising individuals and communities to develop resilience, achieving sustainable behaviour and lifestyle changes, and joining up our services at neighbourhood level with the needs of the individuals and families at the centre.

The following recommendations are based on the analysis of the health outcomes and their determinants in Lancashire. They are aimed to promote wellbeing, prevent ill health and prolong quality of life. They cannot be solely achieved by a single organisation and therefore requires partnership working across Lancashire. They are intentionally broad and complement the start well, live well and age well elements of Lancashire's Health and Wellbeing strategy. They form the basis for public health action and the prevention efforts across the public services.

Implemented alongside other initiatives in the context of NHS Five Year Forward View and the Sustainability and Transformation Plan, they are highly likely to help achieve the Triple Aim in Lancashire. Progress on the recommendations will be reported in the subsequent reports of the Director of Public Health.

Create the conditions for wellbeing and health	
A	Ensure a best start in life for our children and young people, including systematically implementing the healthy child programme[12] across Lancashire.
B	Achieve year on year improvement on all the Marmot indicators for socioeconomic and environmental determinants of health.
C	Systematically proliferate the grass roots community development approaches that we have already got to mobilise and build community capacity to improve our resilience, health and wellbeing.
D	Promote healthy living environments by addressing the variation in road safety (particularly for children), housing standards and fuel poverty, and access to green space, cycling and walking paths across Lancashire.
E	Facilitate the development of a Dementia Friendly Lancashire by supporting the dementia friendly communities and programmes to support raising awareness, early detection and supporting people with dementia.

12 https://www.gov.uk/government/publications/healthy-child-programme-rapid-review-to-update-evidence

Enable Sustainable behaviour and lifestyle changes	
F	Continue to enable the citizens of Lancashire to adopt healthier lifestyles through a comprehensive behaviour change approach to tackle smoking, physical inactivity, obesity, alcohol consumption.
G	Promote workplace wellbeing by encouraging the businesses and other public sector bodies in Lancashire to adopt the workplace wellbeing charter.
Ensure we have a joined up public service to provide right care at the right time at the right place	
H	Adopt a neighbourhood based approach to identify and deliver care, paticulary in supporting the most vulnerable and complex individuals and families across all ages through a joined up targeted early help and crisis support across the public services sector.
I	Improve access to support emotional wellbeing of our children and young people and social isolation/loneliness in older people.
J	Support individuals with long term conditions and their carers with self-management tools to promote their independence and reduce emergency admissions.
K	Achieve continuous improvement on the quality of care and savings opportunities across the care pathways from prevention to end of life care, and supporting complex individuals as identified by the NHS Right Care programme.
Develop the right environment for public service innovation and improvement	
L	Develop a digital roadmap that embraces the opportunities presented by the digital technologies, internet and the social media to achieve the Triple Aim.
M	Support the development of core competencies for place based working across the public sector workforce, including their ability to make every contact count to improve the wellbeing of the residents and communities they serve.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