Investing in Our Health and Wellbeing

Report of the Director of Public Health, 2019/20

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Lancashire County Council

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Foreword

"Investing in our health and wellbeing" follows on from my last report in 2016 on securing our health and wellbeing. The report presents evidence and highlights three main health and wellbeing issues facing our county. They are:

1. We have been adding years to our lives but not necessarily life to our years.
2. Health inequalities are widening in our county compared to national trends, and require systematic action across the public, private and voluntary sectors in partnership with local communities.
3. Protecting and promoting good health and wellbeing is not just a social issue but is also becoming a critical factor for our local and national economic productivity.

If we fail to focus on prevention and keeping people well, it is likely to be even more challenging in improving key wellbeing measures such as healthy life expectancy. Crucially, this will have an impact on our ability to make Lancashire the best place to live, work, visit and prosper.

In the current context of increasing budgetary pressures in health, social care and other public services, the need to invest in prevention of ill health is stronger than ever. Only 20% of our health is determined by access to good quality services in the NHS. Although the NHS Long Term Plan sets out a strengthened focus on preventing poor health, including action on smoking, obesity and Type 2 diabetes, alcohol and air pollution, we also need community level grass roots social movement for health. New and innovative cross sectoral partnerships across education, housing and business sectors across the county can make a positive difference to the lives of our residents. This includes embedding health in our local industrial strategy, promoting more inclusive growth through our local enterprise partnership, and pursuing a carbon neutral economy.

This report identifies health as our best wealth, and recommends key evidence based opportunities for action across four themes. They are:

1. Giving our children the best start in their life,
2. Investing in our communities,
3. Focussing on health as an economic asset, and
4. Looking after our own health and wellbeing

A system wide response to addressing health inequalities must now be our collective priority. I remain committed to our original vision to develop Lancashire into a safer, fairer and healthier place by working with our residents and all our stakeholders.

Best wishes

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Director of Public Health and Wellbeing

1. About Lancashire

Lancashire[1] has a population estimate of approximately 1.21 million spread over 2,900 km^2. The average population density (people per km^2) is 413, compared to the North West average of 512 and an England and Wales average of 387.

The population is projected to increase by 3.5% in the 25 year period, 2016-2041, with the number expected to reach 1.23 million by 2041. The estimated increases are lower than the average for the North West (6.4%), and well below the expected increase for England of 12.1%. At a district level, Burnley, Hyndburn, Pendle and Preston are predicted to see small population decreases between 2016 and 2041, whilst Chorley is the only Lancashire authority with a projected increase higher than the North West or England average.

Analysis by age shows the number of children aged 0 to 15 in Lancashire will rise for the next eight years before beginning to decline. The working-age population is predicted to start to decline within five years and the older population is predicted to continue to increase. There will be more people in the 85+ age range each year as life expectancy increases over the period. The old age dependency ratio (number of people on state pension per 1,000 people of working age), is predicted to increase in every district over the period of the projection, with Fylde seeing the largest increase (496 in 2016 to 685 in 2041).

The 2011 census showed that the largest ethnic group in Lancashire is white (92%), with Black, Asian and Minority Ethnic (BAME) groups making up 8% of the population. Of these, the majority of this group were Asian/Asian British. Numerically, there were over 90,000 BAME people in the county. Three-quarters of the BAME population reside in Preston, Pendle, Burnley and Hyndburn. Across England and Wales the white population accounted for 86% and BAME 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 found on the Lancashire Insight webpages. There are six NHS clinical commissioning groups (CCGs) in the county council area and one in each of the unitary councils. Lancashire is also served by several key NHS Trusts, 173 GP practices (August 2019), over 270 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 (the 12 district councils and the two unitary authorities).
Key strategic partnerships in the county council area include a health and wellbeing board, adult and children safeguarding boards, and the Lancashire Enterprise Partnership. There are three main university campuses in the county, and specialist agriculture and maritime college facilities.

2. Our Health, Our Wealth

There is an inextricable link between our health and wealth and this report draws attention to the main areas for joint collaboration and action to achieve inclusive growth across Lancashire.

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 data for Lancashire is shown in the table below.

Table 1: Life expectancy and Healthy Life Expectancy (in years), females and males in Lancashire compared to England (2015-17).

Indicator	Female	Male
Life expectancy at birth in years (Lancashire)	82.2	78.6
Life expectancy at birth (England)	83.1	79.6
Gap between most and least deprived areas in Lancashire	8.1	10.2
Healthy life expectancy at birth (HLE) in Lancashire	64.5	61.1
Healthy life expectancy at birth in England	63.8	63.4
Gap in HLE between most and least deprived areas in Lancashire*	15.6	15.8

*This indicator is for 2009-2013 Source: Lancashire Insight – life expectancy

The life expectancy at birth for both females and males has been increasing over the past ten years. However, there is a gap of 8.1 and 10.2 years between our least and most deprived areas for females and males respectively.

Within Lancashire the gap in female LE between most and least deprived areas has widened (7.8 years in 2010-12 to 8.1 years in 2015-17)

The average number of years a female child can expect to live in good health, (healthy life expectancy), is 64.5 years, meaning they will spend 17.7 years in poor health.

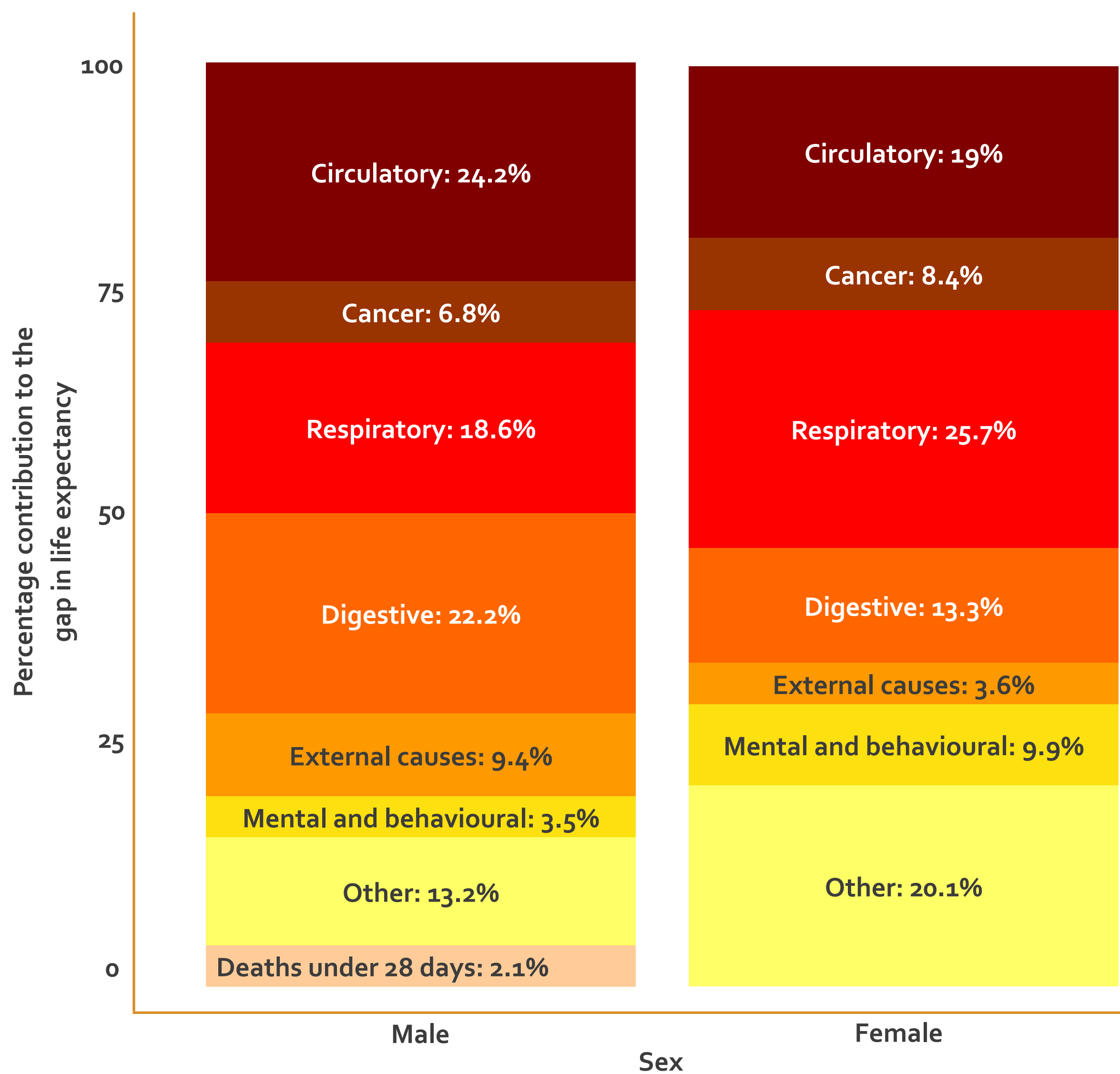
> We have added life to years but not necessarily years to life. Healthy life expectancy in males has decreased since 2009. If not addressed, this is likely to affect the economy and productivity of our workforce

The average number of years a male child can expect to live in good health, (healthy life expectancy), is 61.1 years, meaning they will spend 17.5 years in poor health. Male HLE has been decreasing since 2009-11 and is significantly worse than the England average.

2.2 Causes of excess deaths

A 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. The causes of death that are driving inequalities in life expectancy at Lancashire level are shown in the chart below. Targeting the causes of death which contribute most to the life expectancy gap should have the biggest impact on reducing inequalities.

Chart 1: Breakdown of the life expectancy gap between Lancashire as a whole and England as a whole, by broad cause of death, 2015-17.



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 the gap caused by a significantly higher proportion of external causes for men (including deaths from injury, poisoning and suicide). The table overleaf shows the absolute numbers of excess deaths.

Table 2: Breakdown of the life expectancy gap between Lancashire as a whole and England as a whole, by broad cause of death, 2015-2017

	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	4,937	360	24.2	4,567	241	19.0
Cancer	5,314	91	6.8	4,565	45	8.4
Respiratory	2,655	303	18.6	2,907	423	25.7
Digestive	1,002	185	22.2	955	115	13.3
External causes	770	- 1	9.4	481	- 5	3.6
Behavioural	1,540	95	3.5	3,075	235	9.9
Other	1,928	114	13.2	2,479	225	20.1
Deaths under 28 days	67	5	2.1	47	-	-
Total	18,213	1,152	100	19,076	1,279	100

Source: Public Health England Segment Tool

This means there were at least 2,430 excess deaths in Lancashire between 2015 and 2017 compared to the England average.

2.3 Inequalities within Lancashire

Public Health England has produced an 'at a glance' profile, which give a snapshot of the health of the population in Lancashire. The profile includes key indicators around the wider determinants of health, health improvement, health protection, and healthcare and premature mortality. The profile includes the recent trends and changes from previous values. To view the profile please click on the link here.

A framework of indicators known as the Marmot indicators are another measure of inequalities published for local authorities in England. Analysis of the most recent published data shows that Lancashire is significantly better than the national average in some areas such as long-term claimants of Jobseeker's Allowance but significantly worse than the national average in other areas such as:

- GCSE achieved 5A*- C including English and maths with free school meal status (%).
- Good level of development at age 5 (%) (improving based on recent trend).
- Good level of development at age 5 with free school meal status (%) (improving based on recent trend).
- Fuel poverty for high fuel cost households (%) (getting worse based on recent trend).

It should be noted that there is also significant variation between the districts within Lancashire.

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'[2], was published in February 2010, and concluded that reducing health inequalities would require action on six policy objectives, which are still relevant in 2019:

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

The policy objectives 1, 3, 5 and 6 form the basis for this year's public health report.

3. Investing in giving children the best start in life

A key recommendation in the previous public health annual report[3] was to ensure the best start in life for our children and young people, including systematically implementing the Healthy Child Programme across Lancashire. A lot has been achieved since the last report, including a new partnership between Lancashire County Council and Virgin Care which will see health visiting and school nursing services across Lancashire transformed over the next three years. Running alongside this is a refresh of the council's approach to early help, with the early years as a key focus, ensuring that families and carers receive the right support at the right time in the right way. Lancashire is committed to ensuring services are offered as early as possible and are coordinated, integrated, accessible and personalised to the needs and strengths of individual children, young people and families.

3.1 Why it matters

The Marmot Report on health inequalities cited evidence that development begins before birth and that the health of a baby is crucially affected by the health and wellbeing of the mother. Key factors for poor development outcomes include:

- Parental depression
- Parental illness or disability
- Smoking in pregnancy
- Parent at risk of alcoholism
- Domestic violence
- Financial stress
- Parental worklessness
- Teenage mother
- Parental lack of basic skills, which limits daily activities
- Household overcrowding

The Marmot report states:

'The foundations for virtually every aspect of human development – physical, intellectual and emotional – are laid in early childhood. What happens during these early years (starting in the womb) has lifelong effects on many aspects of health and wellbeing.'

Marmot showed that of about 700,000 children born in 2010, if policies could be implemented to eradicate health inequalities, then each child could expect to live two years longer.

Child poverty has short, medium- and long-term consequences for individuals, families, neighbourhoods, society and the economy. These consequences relate to health, education, employment, behaviour, finance, relationships and subjective wellbeing. Therefore, there are economic and social arguments for investing in childhood. The Family Nurse Partnership estimated savings five times greater than the cost of the programme in the form of reduced welfare and criminal justice expenditures; higher tax revenues and improved physical and mental health.

3.2 What is the current picture in Lancashire?

Overall, comparing local indicators with England averages, the health and wellbeing of children in Lancashire is mixed.

Key issues (from the Lancashire Child Health Profile 2019):

- The infant mortality rate is worse than England with an average of 62 infants dying before the age of one year each year. Recently there have been 33 child deaths (1-17-year olds) each year on average.
- The teenage pregnancy rate is worse than England (now showing signs of improvement), with 440 girls becoming pregnant in a year.
- 13.4% of women smoke while pregnant which is worse than England (2018/19).
- The Measles, Mumps and Rubella (MMR) immunisation level does not meet recommended coverage (95%). By age two, 91.4% of children have had one dose (2018/19 data).
- Dental health is worse than England. 34.0% of 5-year olds have one or more decayed, filled or missing teeth.
- Over a fifth of reception children (23.5%) aged 4-5 are overweight or obese, higher than England (22.6%). This rises to one in three for year six children (34.5%), similar to England (34.3%) (2018/19).
- The rate of child inpatient admissions for mental health conditions at 98.8 per 100,000 is worse than England.
- The rate for self-harm at 439.3 per 100,000 is similar to England.
- Over a three-year period, 224 children were killed or seriously injured on the roads. This gives a worse rate than England.

Monitoring infant deaths remains a priority and the Child Death Overview Panel 2018-2019 annual report provides information on trends and patterns in the deaths reviewed in the last reporting year (2018-2019) and on all deaths since the panel began in 2008, across the Lancashire-14 area. The Lancashire-14 area incorporates the two additional unitary authorities of Blackburn with Darwen and Blackpool.

Investing in new partnerships

The new partnership between Lancashire County Council and Virgin Care which launched on Monday 1 April 2019, will see health visiting and school nursing services across Lancashire transformed over the next three years.

More than 400 health visitors, school nurses and other health professionals are part of the new partnership, which will be known as the "Lancashire Healthy Young Person and Family Service", delivering the three year transformation programme which will give new families and young people access to additional support, free up professionals from their desks to spend more time in the community and mean extra help for the most vulnerable.

The new partnership will see most of the key foundations of the new service – such as new 'hub' and 'spoke' bases for staff based around Preston, Burnley and Lancaster, and new technology to support mobile working – live from the very start.

3.3 What makes a difference?

The most effective interventions are often those that are preventive instead of reactive. Preventive interventions address risk factors (mentioned earlier in this chapter) likely to result in future problems for particular families, without waiting for those problems to emerge.

- A joined-up approach "whole system around the child / family, less fragmented".
- Helping children, families and communities to secure outcomes for themselves, laying the foundations for good parenting including a healthy pregnancy.
- Breaking cycles of poverty, inequality and poor outcomes in and through early years (substance misuse; debt; poor housing, low income, poverty, worklessness, domestic abuse).
- Focus on engagement and empowerment of children, families and communities – e.g. through motivational interviewing to build skills and resilience.
- Using the strengths of universal services to deliver prevention and early intervention – identify needs and risks early.
- The safer sleep for baby campaign aims to raise awareness of safer sleeping for babies and focuses on six easy. steps for parents/carers to follow to make sleep safer, and potentially reduce the risk of Sudden Infant Death Syndrome (cot death).
- Putting quality at the heart of service delivery – skills, knowledge, attitudes and qualifications of the workforce.
- Services that meet the needs of children and families across the social gradient – integrated education and childcare services.
- Reducing barriers to access, particularly transport, improving outcomes and children's quality of life through play.
- Multi-agency pathways of care, based on robust evidence including strategic leadership.
- More effective collaboration between public, private and third sector.

3.4 Recommendations / future challenges

1. Joining up commissioning within the Local Authority for children's public health, early years and wider family services including education.

2. Joint commissioning between Local Authority, CCGs (which commission NHS children services) for services around the child and family.

3. Refreshed early help and early years strategies and delivery plans.

4. A renewed focus to help families, children and communities build skills, local capacity and resilience to be able to secure positive outcomes for themselves and each other.

4. Investing in our communities

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. Place based planning is based on key actions to strengthen community action, civic service integration and service engagement with communities[4].

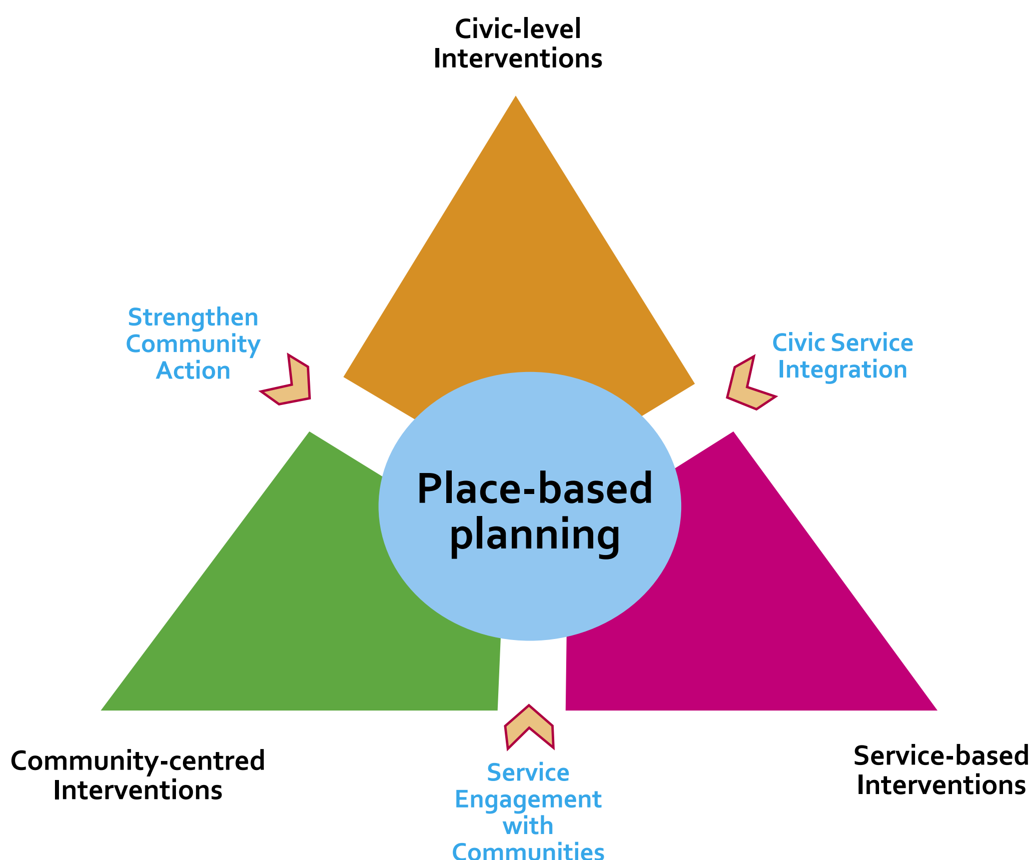
Lancashire County Council is ranked as the most deprived out of the 26 two-tier county council areas in England, and 78th out of all 151 upper-tier local authorities. The county council has 24.7% (187) of its 756 Lower Super Output Areas (LSOAs) in the 20% most deprived nationally, an increase from the 22% (166) in the 2015 indices. 18.3% (138) of county council's LSOAs are in the 20% least deprived nationally, a fall from 18.8% (142) in the 2015 indices.

Burnley is the most deprived lower-tier authority area within the county council area, with an IMD rank of average rank of 11, where one is the most deprived, and 317 is the least deprived in England. Hyndburn, Pendle and Preston are also in the 20% most deprived areas in England on this measure. Ribble Valley is the only Lancashire district in the least deprived 20% of authority areas.

Burnley, Hyndburn, Lancaster, Pendle and Preston are also ranked in the 20% most deprived areas in England for the health deprivation and disability rank of average rank measure and the living environment rank of average rank measure. For the employment deprivation rank of average rank, Burnley, Hyndburn, Pendle, Preston and Rossendale are in the 20% most deprived areas in England for this measure.

Effective place-based action requires action on civic, service and community interventions, along with system leadership and planning.

Figure 1: The Population Intervention Triangle model (PIT)



4.1 Why it matters

Place matters.
We live our lives in neighbourhoods – so it makes sense for them to be the starting point for how we think about services. Working at a neighbourhood level – with communities who understand both the challenges local people face and the strengths they have to overcome them – can help find creative solutions to seemingly insurmountable problems.

Quite simply where you live affects your health, people living in the most deprived areas spend nearly a third of their lives in poor health, compared with only about a sixth for those in the least deprived areas. Not only are health inequalities socially unjust they are preventable. They cut people's lives short and lead to avoidable years living with impaired health and wellbeing. In addition to this personal cost there are also costs the NHS, local authorities and our national and local economies which amount to billions of pounds each year.

The causes of health inequalities are a complex mix of environmental and social factors which play out in a local area, or place – this means that local areas have a critical role to play in reducing health inequalities. Many of the solutions to challenges such as improving the public's health need to be much more rooted in local circumstances. We often identify groups of people that need extra help and target them – we do that less well with places. If we are to invest in our communities to maximise the benefits to health we should focus on the neighbourhoods which are doing less well and target our resource and effort there. This needs to be firmly embedded in the neighbourhood and start from a position of what does this place have that's good.

The 'asset approach' is an approach which builds on the assets and strengths of specific communities and engages citizens in taking action for themselves, not only is this empowering it is also cost-effective and sustainable.
It harnesses the resources of citizens, community groups and the third sector to complement the work of the public sector. Given the growing financial pressures these are important benefits. In short – we all win, communities and citizens take control of what makes them well, which frees up public sector resource for those who simply are not able to take personal responsibility and need our help.

This approach does not come for free, we must invest time, resources and support in our communities to help them to thrive. Healthy and resilient communities which are strong and supportive of each other do not depend on the support of statutory services. However creating and sustaining this approach does require organisations to work differently, and will only be achieved through services collaborating with communities on what will help them to flourish. An important, pressing issue facing communities and statutory services is the climate emergency on which we are working together to harness our mutual assets.

4.2 What's the picture in Lancashire?

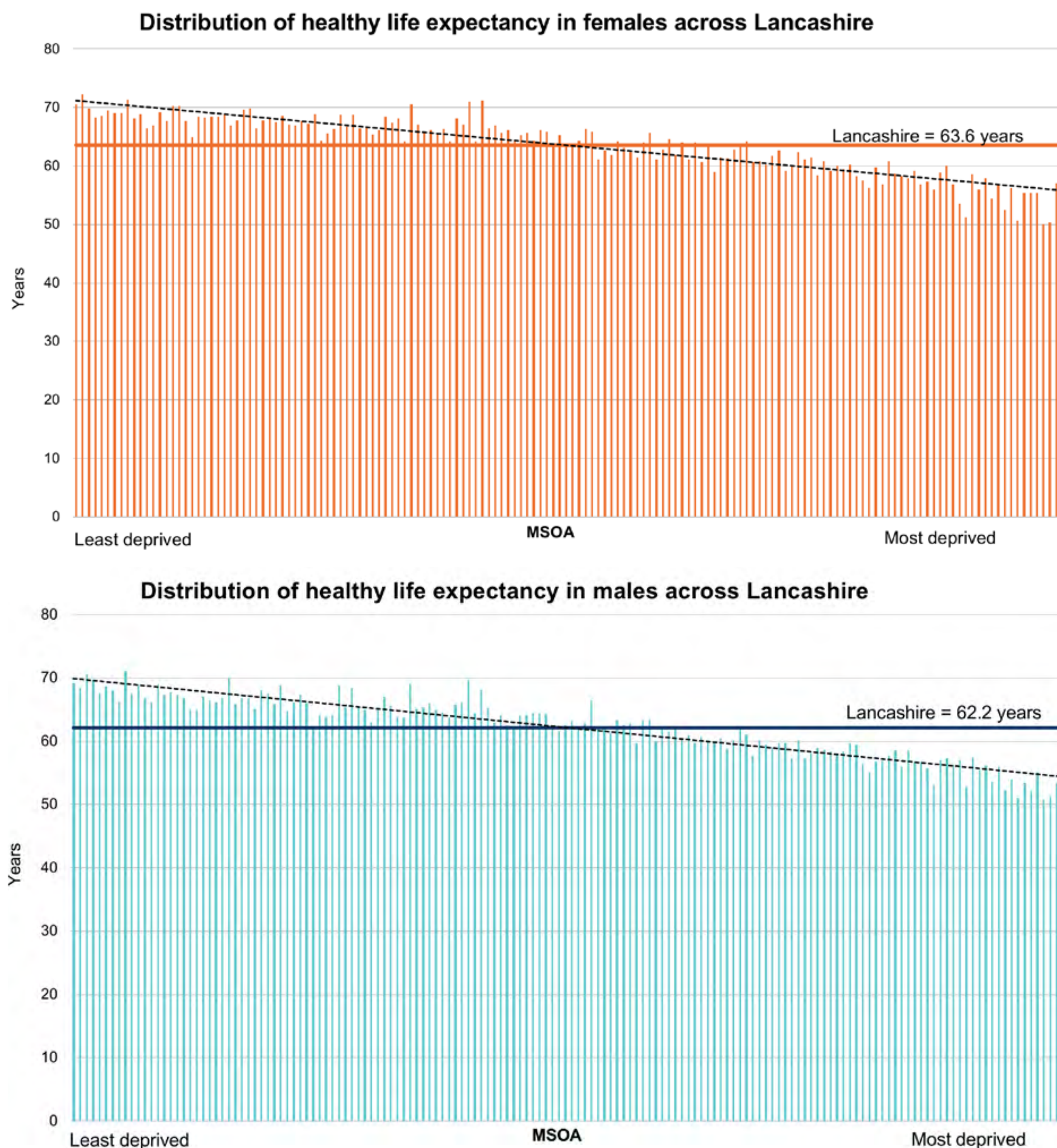
These inequalities are not just between the most deprived areas and the rest. In fact they exist across our social gradient. We need to up our game across all sections of our society.

As we saw above the increasing gap in life expectancy between the most and least deprived areas gives us cause for concern.

Extreme inequalities can be found across a range of indicators; the percentage of year 6 children who are overweight or obese in Lostock Hall, South Ribble is 25.9% (2015/16-17/18), whereas the percentage is 45.8% in Daneshouse with Stoneyholme (Burnley). In University ward, Preston, the percentage of young people (16-18) not in education, employment or training is 16.4%, while in Eccleston and Mawdesley, Chorley, the figure is only 0.2%.[5]

An important consideration is that these inequalities are not just present between the most deprived areas and the rest of Lancashire. As an illustration, the bar charts show the distribution in female and male healthy life expectancy across the 154 middle-layer super output areas (MSOAs) in Lancashire.

Chart 2: Distribution of female and male healthy life expectancy across Lancashire (2009-13)



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.

There is a strong commitment to tackle health inequalities in Lancashire. This was demonstrated by the completion of the health inequalities joint strategic needs assessment (Health Inequalities JSNA) in 2009, repeated in 2014 and now being undertaken again in 2019 with an expected publication date in March 2020 following the Marmot 10 years on review publication in February 2020.

4.3 What makes a difference

Good neighbourhoods help people have good lives.
Understanding what matters to people where they live and by working with them on the challenges they face can help find creative solutions to seemingly insurmountable problems. Neighbourhoods are where people spend most of their time so it seems obvious that is where the solutions must be. We need to work with our communities to co-create solutions.

In Lancashire we are developing an approach to neighbourhood working, which we call Total Neighbourhoods. We have been working with our health, district council and other partners in the constabulary and Lancashire Fire and Rescue service, as well as the voluntary, community and faith sector (VCFS). We are working together as one team, but this isn't just about how we work better together as organisations, it's about listening to our communities and shaping our services to meet their needs.

We are really starting to make a difference by working in this way with one of our communities, in Fleetwood. Watch this video to see what a difference this is making to the people who live and work there.

Investment in our communities is vital. Living and working conditions and (un)employment are important determinants of health, but healthy, resilient communities are also a vital determinant of a thriving economy. We need to invest in our workforce and commit to working differently 'with' people to change the system in which health and wellbeing is created rather than one which treats and manages conditions. This requires commitment from system leaders. The investment needed is not financial we need to repurpose our all our investment in our communities and work with them to build a sustainable new approach which creates resilience.

4.4 Recommendations / future challenges

5. System leaders should commit to new models of working across the public sector to develop asset based approaches to service delivery, that enhances the capacity and capability within our citizens and communities.

6. Public sector partners should work hard to align and even pool budgets wherever possible to maximise their capacity to improve outcomes for people including tackling the climate emergency and investments in social prescribing.

7. Use our engagement processes to have open conversations with our citizens to develop strong and resilient communities that take responsibility for creating and maintaining their own health and wellbeing that is supported by effective services which they co-create.

5. Investing in our working age population

5.1 Why it matters

Having a healthy and capable working age population (WAP) has major positive impacts at an individual level, for organisations, the local economy and wider society. This means supporting people to achieve their potential in life by enabling them to enter the employment market and maintain financial independence and security for themselves and their families, especially as they age. This is particularly important for people with long term conditions and disabilities, a large number of whom want to work and live independent lives. Additionally, for those in work, it means being able to access fair employment and good work to maintain healthy behaviours, to get the support to stay in work and in the case of sickness absence, return to work promptly.

Infographic 1: Health and financial benefits of moving individuals into employment in the UK

Public Health England

Health**matters**

Health and work

Being in work is better for your health than being out of work

With combined costs from worklessness and sickness absence amounting to over **£100bn annually** there is strong economic case for greater action

PHE's ROI tool shows that every person moving from worklessness into **employment** would save...

£12,035 Per person over a 1 year period

This savings is broken down by:

£540 to local authorities

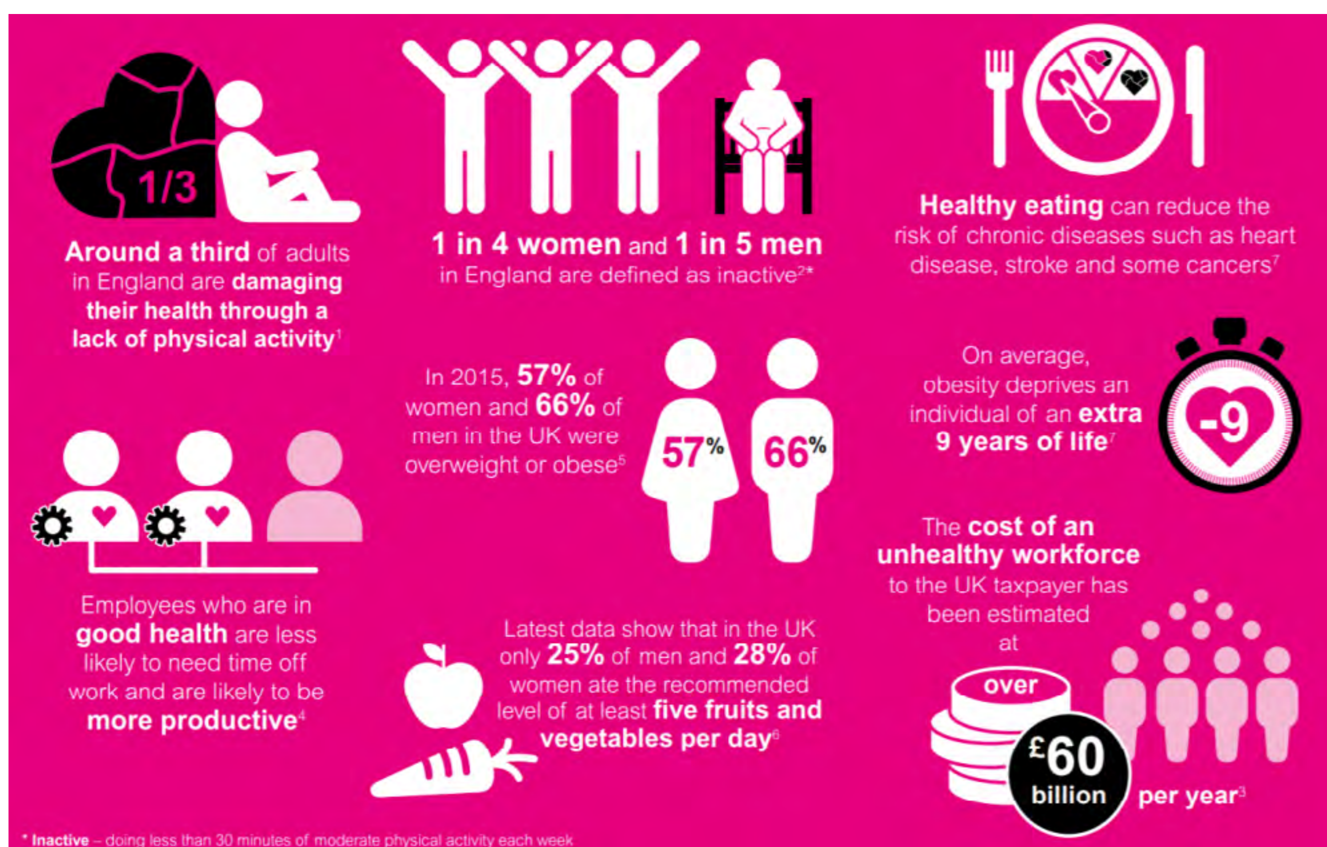
£85 for the NHS

£11,410 to government

Fundamentally, a healthy place is one that has the potential to be a healthy and productive workforce for the local economy. It also drives improvements in wellbeing and narrows the gap in health inequalities. The evidence that unemployment is bad for your health is clear, and keeping people in work or getting people back to work also reduces the number of working-age people claiming out of work benefits and lessens the impact of poverty and social exclusion.

Achieving this will require collaborative, strong and effective management in workplaces, and engagement and communication with communities and individuals, particularly around understanding the impact of the wider determinants of health, personal resilience, health promotion and training and the support for the management of long-term conditions. It is established that many causes of ill health are attributed to modifiable lifestyle factors, such as smoking, physical inactivity, obesity, poor diet, excessive alcohol consumption, and substance use. Other contributory factors include the cumulative impact of living/working conditions. As a person ages they are more at risk of developing debilitating health conditions. Alongside the main causes of mortality, many other conditions can also have a profound impact on individuals, such as musculoskeletal conditions and diabetes, and result in poor health, comorbidity and long-term disability

Infographic 2: The cost of an unhealthy workforce



5.2 What is the current picture nationally and in Lancashire?

The impact of long-term conditions and disability in the WAP is huge, with economic and social costs to both the individual and society in the form of lost productivity and increased health and social care demands.

It is estimated that more than 131.2 million days were lost to sickness absence in the UK in 2017 and working-age ill health could cost the national economy up to £100 billion a year.[5,6] The costs to the taxpayer – benefit costs, additional health costs and forgone taxes – are estimated to be over £60 billion.[7] Since 2003, there has been a general decline in the number of days lost to sickness absence, with the figure falling to a low of 131.7 million days in 2013, but there were increases in 2014 and 2015.

Nationally, it is estimated that 2% of patients comprise 16% of spend on inpatient admissions (2015/16), with the most common conditions of admission for complex patients being circulatory, 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.

In Lancashire key facts about complex patients include:

- The average complex patient has seven admissions per year for three different conditions (based on programme budget categories).
- 61% of these complex patients are aged 65 or over; 38% of these complex patients are aged 75 or over.
- 14% 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 four attendances a year on average.

Table 3: The proportion of CCGs spend on the 2% of their most complex patients is provided in the table below:

CCG (2015/16)	Number of patients	Proportion of CCG spend	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	595	16.8%	12,424
East Lancashire	1,249	16.8%	25,775
West Lancashire	393	16.4%	7,635
Total	3,940		79,553

Source: NHS Clinical Commissioning Group (2015/2016 data)

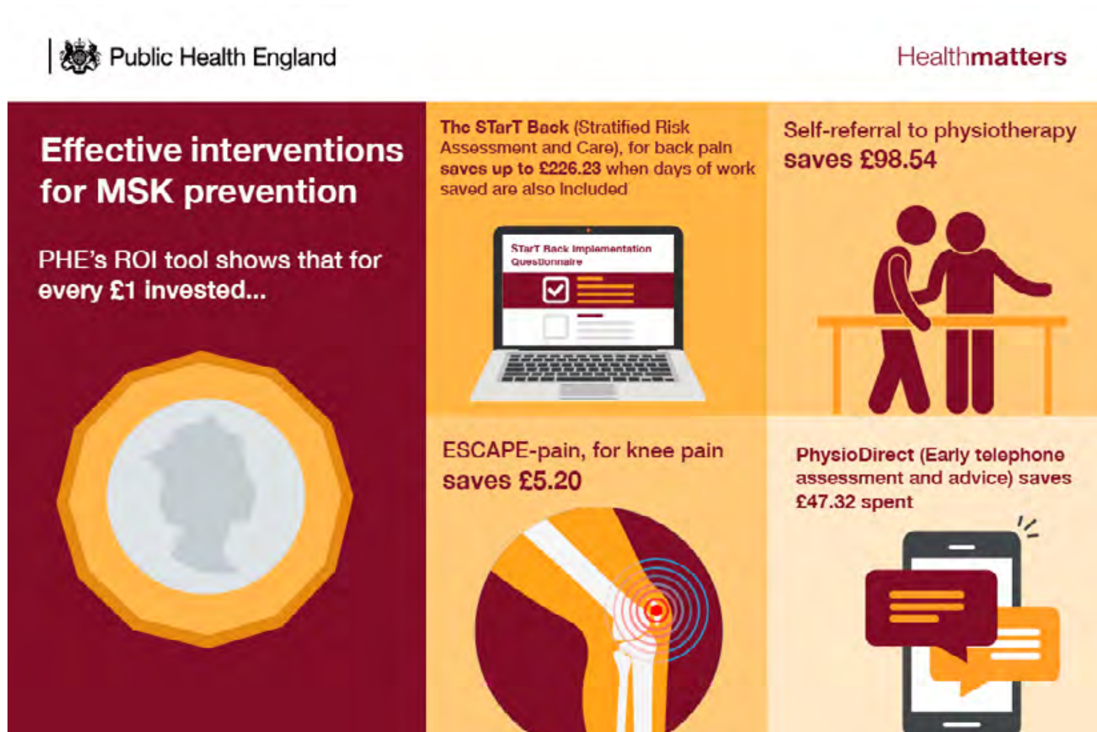
It is estimated that the state pension age for children born in 2019 will be 68 years. It is therefore important to have as much of a healthy and disability-free life expectancy as possible during working age and before reaching the state pension age. Using raw data available at middle super output area (MSOA) level for Lancashire, 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 a healthy working life for our population, and particularly our children.

5.3 What makes a difference

Evidence shows that work, education, training and volunteering are contributors to good physical and mental health and wellbeing. Conversely unemployment, poor quality employment and long-term sickness absence have a harmful impact, with higher rates of mortality, morbidity and a lower quality of life. There also may be fewer opportunities for development and growth, and for people to reach their full potential.

Examples of effective interventions include musculoskeletal (MSK) prevention and supporting employers to help staff improve their health and wellbeing.

Infographic 3: Effective interventions for MSK prevention



Infographic 4: Employer actions to improve workforce health and wellbeing

5.4 Recommendations / challenge

8. Collaborate with leaders in economic growth and local employers across the sectors to develop strategies to promote and deliver a Lancashire Offer for workplace health to promote and manage the health and wellbeing of staff and so support Lancashire businesses to be productive and be able to retain and recruit staff. Encourage employers and staff to adopt carbon neutral modes of transport (e.g. walking, cycling) and work environments.

9. Strategically support employers using what we know works to improve the health and wellbeing of employees (guidance from National Institute for Health and Care Excellence , Local Government Association, Public Health England, Health and Safety Executive). Having an emphasis on organisational culture, engagement, role of line managers and the wider determinants of health is essential to this.

10. Support communities and workplaces in creating and implementing pathways to good jobs, especially for those who want to work and live independent lives. Inclusive growth should be achieved by working together with partners from across the private, public, voluntary sector, primary and community care services.

6. Investing in our own health and wellbeing

6.1 Why it matters

The strong evidence to support investment in preventative interventions has previously been referenced earlier in this report. The potential impact of such interventions cannot be understated as it is estimated that nationally around 40% of all deaths in England are related to the individual behavioural and societal opportunities to make healthier choices. The NHS spends more than £11bn a year on treating illnesses caused by the effects of diet, inactivity, smoking and drinking alcohol.[8]

Strategically it is important to acknowledge that the potential range of preventative interventions to address this is wide ranging and needs to be planned across the life course using an evidence based, needs based approach whilst ensuring that the full range of civic, community and service interventions are appropriately integrated.

In terms of local context it is therefore important to not only highlight the significant impact that empowering communities and individuals to adopt healthier choices can have on broader health and well being as well as focus in on some of the key challenges and opportunities within Lancashire.

6.2 What is the current picture in Lancashire?

The following sections provide some key facts about lifestyle behaviours in Lancashire.

Tobacco

Tobacco use is the biggest risk factor for disability and death globally and continues to present significant harm to the population of Lancashire.

- Tobacco smoking kills over 2,000 adults (aged 35+) in Lancashire each year.
- Smoking prevalence remains slightly higher in Lancashire (14.2% in 2018) compared to England (14.4%), although this figure continues to fall (current smokers aged 18+).
- Just over 13% of women were smoking at the time of delivery, significantly worse than England (10.6%) (2018/19).
- The proportion of young people smoking (9.0%) is similar to England (8.2%) (2014/15).
- The cost of smoking to society in Lancashire is estimated at £269.8m; of this £59m is the cost to the NHS.[9]
- A person smoking 20 cigarettes a day will spend between £3,200 and £4,000 per year (depending on brand).

Excess weight

Obesity is the second leading cause of premature death in Europe and a contributor to a number of non-communicable diseases such as some cancers, cardiovascular disease and type 2 diabetes.[10]

- In Lancashire, the percentage of overweight and obese adults (64.6%) is significantly higher than England (62.0%), with the trend showing a small increase year on year (2015/16 to 2017/18).
- Over a fifth of reception children (23.5%) aged 4-5 are overweight or obese, higher than England (22.6%). This rises to one in three for year six children (34.5%), similar to England (34.3%) (2018/19).
- In England, 71% of people with no qualifications have excess weight (overweight and obese combined), compared to those with a level 4 and above qualification (a degree or higher).[11]
- Estimates indicated the cost of obesity to the NHS was likely to be approximately £6.3bn by 2015, rising to £9.7bn by 2050.

Physical activity

Inactivity, described by the Department of Health as a "silent killer," directly costs the NHS across the UK an estimated £1.06 billion annually and is the fourth leading risk factor for death and disability.

- The health benefits of activity include a 30% lower risk of early death; a 20% lower risk of breast cancer; up to a 35% lower risk of coronary heart disease and stroke; and up to a 50% lower risk of type 2 diabetes.
- Two-thirds of adults (19+ years) in Lancashire are meeting moderate physical activity recommendations, in line with the England proportion (66.3%).
- Just over a fifth of adults (22.0%) are classed as inactive in Lancashire, similar to England (22.2%).
- 664 deaths could be prevented if adults (40-79 years) were engaged in the recommended levels of activity.
- The cost of inactivity to Lancashire is £22.6m per year.[12]

Alcohol

Alcohol consumption can directly affect physical and mental health, and also have wider impact on individuals and society, through increased risk of accidents, and crime and violence for example:

- Alcohol misuse costs almost £21 billion per year in England (Lancashire £495m).
- Of Lancashire's population 1.5% are dependent drinkers, 17.8% are binge drinkers and 22.9% have increasing risk due to alcohol misuse.[13]

6.3 What makes a difference

Investing across the life course is a central tenant of the Government's recent Green paper on Prevention[14]. This paper crucially acknowledged that when considering factors that shape our health and wellbeing, whilst these are indeed likely to vary from person to person and from disease to disease, most people agree that the choices we make, shaped by the conditions in which we live, have the biggest impact. These considerations have been central in formulating our recommendations over how best we invest our energies, time and resources in order to maximise individual behavioural and societal opportunities to make healthier choices.

6.4 Recommendations / future challenges

Drawing on some of the emerging national consultation on how we should best achieve this, it is therefore recommended that within Lancashire:

11. Strategically we align our collaborative approaches to prevention with partners across Lancashire ensuring they are able to be predictive, proactive and personalised while ensuring they still maintain their strong focus on our biggest lifestyle challenges referenced above.

12. Continue to develop our 'Health in All Policies' approach to help create environments that support individuals' opportunities to adopt healthy behaviours.

13. Embed further preventative interventions into mainstream service delivery across our range of commissioned services on an integrated basis across both the NHS, social care and the voluntary sector whilst also systematically embedding a culture of 'Make Every Contact Count'.

14. Continue to incorporate a behavioural science approach to some of our biggest challenges around promoting and embedding a culture of healthy lifestyles.

Summary of Recommendations/ Future Challenges

Best start in life

1. Joining up commissioning within the local authority for children's public health, early years and wider family services including education.

2. Joint commissioning between local authority, CCGs (which commission NHS children services) for services around the child and family.

3. Refreshed Early Help and Early Years Strategies and delivery plans.

4. A renewed focus to help families, children and communities build skills, local capacity and resilience to be able to secure positive outcomes for themselves and each other.

Investing in our communities

5. System leaders should commit to new models of working across the public sector to develop asset based approaches to service delivery,that enhances the capacity and capability within our citizens and communities.

6. Public sector partners should work hard to align and even pool budgets wherever possible to maximise their capacity to improve outcomes for people including tackling the climate emergency and investments in social prescribing.

7. Use our engagement processes to have open conversations with our citizens to develop strong and resilient communities that take responsibility for creating and maintaining their own health and wellbeing that is supported by effective services which they co-create.

Working age population

8. Collaborate with leaders in economic growth and local employers across anchor institutions to develop strategies to promote and deliver a Lancashire Offer for workplace health to promote and manage the health and wellbeing of staff and so support Lancashire businesses to be productive and be able to retain and recruit staff. Encourage employers and staff to adopt carbon neutral modes of transport (e.g. walking, cycling) and work environments.

9. Strategically support employers using what we know works to improve the health and wellbeing of employees (guidance from National Institute for Health and Care Excellence , Local Government Association, Public Health England, Health and Safety Executive). Having an emphasis on organisational culture, engagement, role of line managers and the wider determinants of health is essential to this.

10. Support communities and workplaces in creating and implementing pathways to good jobs, especially for those who want to work and live independent lives. Inclusive growth should be achieved by working together with partners from across the private, public, voluntary sector, primary and community care services.

Our own health and wellbeing

Drawing on some of the emerging national consultation on how best we should best achieve this, it is therefore recommended that within Lancashire:

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References

1 'Lancashire' in the context of this report refers to the twelve local authority districts in the county council area and does not include the two unitary authorities of Blackburn with Darwen and Blackpool.

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