Report of the Interim Director of Public Health

Agenda Item No: 10
Meeting:

NORTH LINCOLNSHIRE COUNCIL

HEALTH AND WELLBEING BOARD

Northern Lincolnshire Burden of Disease Report 2016 Main Findings and key issues for North Lincolnshire

1. OBJECT AND KEY POINTS IN THIS REPORT

To ask North Lincolnshire Health and Wellbeing Board members to consider the content of this report and the detail of the 'Burden of Disease in Northern Lincolnshire' report, available at Appendix 1 and published at http://nldo.northlincs.gov.uk/IAS_Live/sa/jsna/adults

2. BACKGROUND INFORMATION

2.1 In February 2016, The Healthy Lives Healthy Futures Programme Board commissioned a 'Burden of Disease' report. The objectives were to:

- Summarise the current burden of disease in North and North East Lincolnshire
- Predict the future burden & identify opportunities to intervene earlier
- Inform a 'system – wide' approach to prevention in North Lincolnshire
- Focus on 'at scale' evidence based interventions which could inform local commissioning and the Northern Lincolnshire element of the local Sustainability and Transformation Plan submission (STP)

2.2 The work was led by Professor Chris Bentley with support from public health analysts from both Councils. The report was completed in May 2016, and was presented at a joint Northern Lincolnshire prevention conference in July and published in August 2016.

2.3 The report was written in the context of increasing life expectancy, a growing elderly population and above average rates of smoking, obesity, chronic disease and use of urgent care in North Lincolnshire, alongside rising pressures on public sector resources.

2.4 The full report, which includes an executive summary is available at Appendix 1. The information presented in paragraphs 2.5 to 2.14 below highlight the key findings and implications for North Lincolnshire.

2.5 **Social determinants of health and wellbeing**. The report identifies significant health inequalities in North Lincolnshire between men and women and between income groups. It delivers a strong message that managing the social determinants of health and wellbeing across the life course will substantially reduce the burden of disease in North Lincolnshire, with a key focus on 'at scale' population wide interventions aimed at narrowing the gap in:

- Early years development
- Skills development and sustainable employment
- Income and debt management

2.6 Risk behaviours and conditions

The report confirms the leading risk *behaviours* that contribute to the local disease burden as diet, tobacco, alcohol & drug use, low physical activity and occupational risks, with all risks being greater amongst men than women.

The main risk *conditions* that are potentially preventable and/or manageable within the community include a high BMI, raised blood pressure, high cholesterol and raised blood sugar.

Whilst the incidence of some of these behaviours and conditions has declined across the population as a whole in the last decade, (eg smoking), the incidence of other risks (eg obesity) has risen. Moreover, these risks have become more polarised in the population and are more likely to cluster together in our most deprived communities.

Reducing these behaviours and conditions will require a systematic evidence based and multi-faceted approach to risk reduction, tailored to the needs of men, as well as to the complex needs and challenging circumstances of our most deprived communities, developed at sufficient scale to make a difference to overall health outcomes, capitalising on the skills and capacity of all front line services.

2.7 **Early mortality, disability and poor health amongst the most deprived**

From the age of 45 years North Lincolnshire's most deprived 20% residents have elevated rates of death and ill health associated with cancer, heart disease and respiratory disease. The highest rates being observed amongst men.

Our most deprived residents are also more likely to develop multiple long term conditions at a much younger age than their better off peers. Yet health seeking behaviour and self-care can present major challenges for this group, as illustrated by the differential use of planned, urgent healthcare and public health interventions, (such as screening) in North Lincolnshire.

2.8 **Differential use of healthcare and public health interventions**

The use of urgent, unscheduled care in North Lincolnshire is strongly associated with deprivation, especially amongst men aged 45 years and older, with the most deprived making more use of A&E and emergency hospital admissions. Planned care does not follow the same pattern, suggesting a greater dependency on crisis management, poorer self-care and potential unmet need/access in North Lincolnshire's most deprived communities.

North Lincolnshire already has much higher levels and rates of use of urgent care across all population groups, compared with the national average and with neighbouring North East Lincolnshire, suggesting potential differences in referral cultures or policy, as well as access to primary and community health care between the two districts.

2.9 **Variation in implementation of optimal care for people with long term conditions**

At the same time there is significant variation in the presentation and management of people with existing long term conditions within primary care, suggesting the need for greater systematic support in primary care to improve patient access to optimal care and to standardise quality and cost effective outcomes for local residents.

2.10 **Increasing frailty**

Frailty is a transitional state of vulnerability to accumulated impairments, and affects 20 – 50% of people aged 80+ years. The five main frailty syndromes include falls; immobility; delirium; incontinence; and susceptibility to the side effects of medication

Older people often present in crisis because of these and other problems, without prior warning to urgent or emergency care services, with such episodes often precipitating further decline. For example, physical frailty and dementia are the main causes of patients entering long-term social home or residential care.

However, frailty is not a static condition and outcomes can be improved through earlier identification, enabling prevention plans and contingency arrangements to be put in place. In relation to dementia for example, and through substantial improvements in 'pathway' co-ordination there have been measurable improvements in:

- Retained (supported) independence, and deferred entry to residential care
- Reduction in the numbers presenting in crisis to social care, emergency departments and urgent care centres
- Reduction in the number of avoidable hospital admissions/bed days for patients with a dementia diagnosis.

Similar advantages could be gained through a formalised recognition of the state of frailty. A further advantage is that, unlike dementia at present, progressive degrees of frailty can be halted and even reversed with pro-active approaches.

2.11 **Functional decline**

As with frailty, functional decline can be managed in many cases, where resources are deployed effectively. The supports include: proactive health promotion; rehabilitation following an acute episode or crisis; and re-ablement. However as with all points in the burden of disease 'pathway' there are a range of social determinants that will affect the effectiveness and cost effectiveness of these interventions, including;

- Personal skills, and capacity to self-manage
- Family and carer involvement
- Other social networks; otherwise, loneliness and isolation
- Mental wellbeing
- Physical resources for maintenance and recovery (including financial resources)

2.12 **Future burden of disease**

Analysis shows that some of the most prevalent causes of the current and future disease burden, particularly in an ageing population, are not necessarily those with the highest profile strategically. These include:

- Sensory loss: material is available to support strategic approaches to sight loss, but much less so for hearing loss. Both are very important contributors to frailty, isolation, loneliness and loss of independence
- Back and neck pain is a significant burden, and overshadows even arthritis as a reported concern, with less systematic management pathways.
- Depression and anxiety: is the major burden of disease amongst young people and working age adults and peaks in middle years.

The report suggests a system wide response to preventing and managing these conditions, to ensure consistent and cost effective practice, with strong preventive interventions and active management.

2.13 **Implications for a population based approach**

The report describes some key components of a population based strategy to reducing the burden of disease, including.

- Commitment of effort and resource needs targeted proportionately to complexity of need.
- Multifaceted approaches delivered with system and scale, including:
  - Population level protections: legislation; taxation, licencing; heathy public policy
  - Systematic, scaled and sustainable delivery of evidence based services
  - Systematic engagement with communities to provide supportive networks and environment
  - Connectivity of services with communities, including strategic engagement of the 3rd sector
- Pro-actively addressing 'intervention decay' by drawing the 'missing thousands' appropriately into services, especially where deprivation is highest. The components of intervention decay are identified as follows:
  - Primary - under recognition of illness by individuals and people around them
  - Secondary – identified as ill but treatment not accessible
  - Inadequacies in quality of in-service provision

- Insufficient assets for recovery or ongoing self-management

2.14 **Intervention 'best buys'**

The report concludes with examples of some 'best buy' approaches to reduce the burden of disease in North Lincolnshire which should be incorporated into any new place based models of out of hospital care.

- Capitalising on frontline service contacts, with a systematic Making Every Contact Count (MECC) approach, backed with brief intervention training and support.
- Targeting high risk individuals with multiple risks (e.g. smokers on LTC registers) for greatest impact.
- Developing system wide approaches to preventing and managing the leading causes of the burden of disease, including systematic approaches to managing frailty and multi-morbidity across the pathway.
- Developing at scale, system and population wide interventions aimed at narrowing the gap in, early years development, skills and sustainable employment, income and debt management
- Identifying and connecting effectively with communities to enable residents to self-care more effectively.
- Systematic approaches to reducing variation in quality and outcomes in primary care

3. OPTIONS FOR CONSIDERATION

3.1 Accept the report and take actions described in the recommendations.
3.2 Accept the report and take other actions as deemed appropriate,
3.3. Not accept the report

4. ANALYSIS OF OPTIONS

4.1 Adopting the recommendations would improve the health and wellbeing of residents of Northern Lincolnshire and reduce the burden of disease in North Lincolnshire. The Board may also wish to discuss other potential actions.

5. RESOURCE IMPLICATIONS (FINANCIAL, STAFFING, PROPERTY, IT)

5.1 None as a direct consequence of this report.

6. OUTCOMES OF INTEGRATED IMPACT ASSESSMENT (IF APPLICABLE)

6.1 N/A.

7. OUTCOMES OF CONSULTATION AND CONFLICTS OF INTERESTS DECLARED

7.2 No conflicts of interest declared.

8. RECOMMENDATIONS

8.1 To develop a local action plan which addresses the key themes and recommendations of the Burden of Disease report.

8.2 To use the findings to inform next year's review of North Lincolnshire's Joint Health and Wellbeing Strategy.

8.3 To use the findings and recommendations of the Burden of Disease report to inform an integrated, system wide, place based approach to health and wellbeing improvement in North Lincolnshire and across our developing care networks.

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