

Working-age population (50-64 years)

Supporting evidence and key findings for
Lancashire-14

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1. Overview

This report focuses on the older working-age population (50-64 years), looking at the factors that can influence the health and wellbeing of this group.

It complements the working-age population (WAP) JSNA, which provides analysis of the current and future needs for the working-age population (16-64) in Lancashire. It uses a wide range of data and resources that can be viewed on the publications section of the [Lancashire Insight](#) web pages.

Rather than take the form of a single document, the WAP JSNA should be regarded as a repository of health and wellbeing related intelligence available for all partners and the public.

Where possible, data and statistics are quoted for the 16-64 population, when this is not available, the age range is clearly identified. Please note, due to the unavailability of certain data, estimates may be used in some instances and not all data are provided at a district level.

The recommendations for the WAP are focused around three areas: healthy people, healthy spaces and healthy workplaces and full details can be found in the [WAP JSNA final report](#).

2. Background information

The population in Lancashire is increasing and population projections suggest that as the older (50+) population rises, fewer young people will be entering the workforce. The resulting vacancies cannot be filled through immigration alone and therefore, older people will be a vital resource to fill the workforce gap. Population projections show over 200,000 people in Lancashire-12 will be aged 50-64 in 2039, which equates to 30% of the 16-64 population. Compared to all ages, this is 16.6% of the total population.

District figures vary, with an overall [small net increase](#) (4.5%) in the whole population of the county to 2039. These estimations are lower than the average for the northwest region as a whole (8.2%) and well below the increase for England (16.5%). The districts with the projected highest rate of 50-64-year olds in the working-age population (in 2039) are Fylde (36.3%), Ribble Valley (35.7%) and Wyre (34.4%), with [appendix one](#) providing further details.

The removal of the traditional retirement age, government policies to extend working lives and other factors, such as people living longer and often in better health, requires a radical shift in how those aged 50+ are viewed in employment terms. The benefits in employing a multi-generational workforce are well documented, and ensuring the population (50+) are fit and healthy for work brings social and economic advantages for the individual and the wider society in general.

There is renewed emphasis on preventing ill health and improving the wider health of the population, which remains poor in many areas across Lancashire. Many health conditions are linked with modifiable lifestyle factors and these are explored in further detail in the WAP lifestyle report and within the individual district profiles available [here](#).

3. Health conditions

As a person ages they are more at risk of developing various health conditions, linked to factors including cellular damage, genetic risk and impact of living/working conditions. The main causes of ill health though are associated with modifiable lifestyle factors such as smoking/tobacco use, physical inactivity, obesity, poor diet/nutrition and excessive alcohol consumption.

The 50+ population have very different health/lifestyles compared to the younger age groups, particularly if they have engaged in behaviours such as smoking or drinking over many years.¹

The leading causes of premature mortality (under-75 years) in Lancashire-12 include cancer, heart disease and stroke, respiratory disease (such as chronic obstructive pulmonary disease), and liver disease. Many conditions, whilst not directly life threatening, such as musculoskeletal conditions, can still have a profound impact on the 50+ population. These are all explored in further detail below.

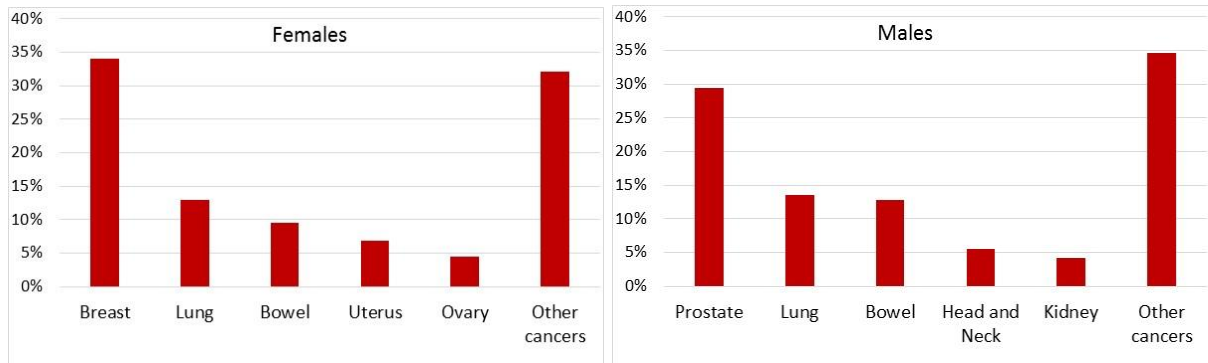
3.1 Cancer

The incidence of cancer diagnosed in the UK every year continues to increase. Unhealthy lifestyle behaviours, alongside improved uptake of screening programmes and better diagnosis, have contributed to the increase.²

When looking at age breakdown, adults aged 50-74 account for over half (53%) of all new cancer cases in the UK, with slightly more cases in males than females. For those aged 50-64, there are more females diagnosed with cancer (41,527 and 44,611 respectively).³ Breast cancer is the most common female cancer and prostate cancer the most common male cancer. Both sexes have similar rates of bowel and lung cancer prevalence.

The figures below show the main cancers in females (50-74) and males (50-74) (2012-14) in the UK.

Figure 1: female and male most common cancers, ages 50-74 in the UK (2012-14)

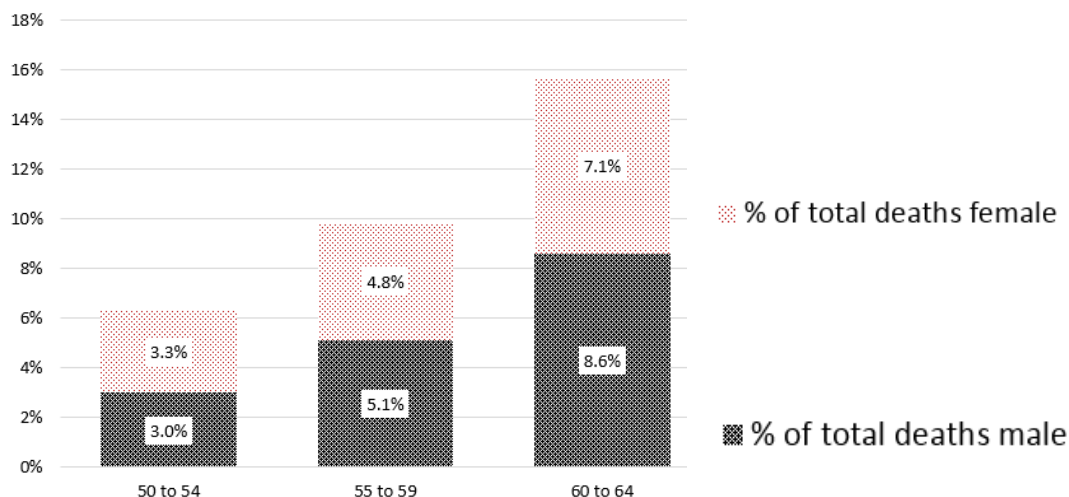


Source: Cancer Research UK, 2017

At a local level, cancer statistics show that Lancashire-12 and Blackburn with Darwen have incidence rates similar to England, while Blackpool's rate is significantly higher, (2012-14).⁴ Almost a tenth (9%) of people aged 45-64 in Lancashire-12 stated they had received a diagnosis of cancer from a health professional, compared to 3% of those aged 16-44 (health behaviours JSNA, 2015).

While the majority of cancer deaths in the UK occur in those people over the age of 75 (52.1%), there are still high rates of mortality for those aged 50-64. Cancer accounts for 39% of all [premature deaths](#) (under-75) in Lancashire-12.

Figure 2: Percentage of total deaths (all ages) from cancer in the UK for those aged 50-64 (2012-14)

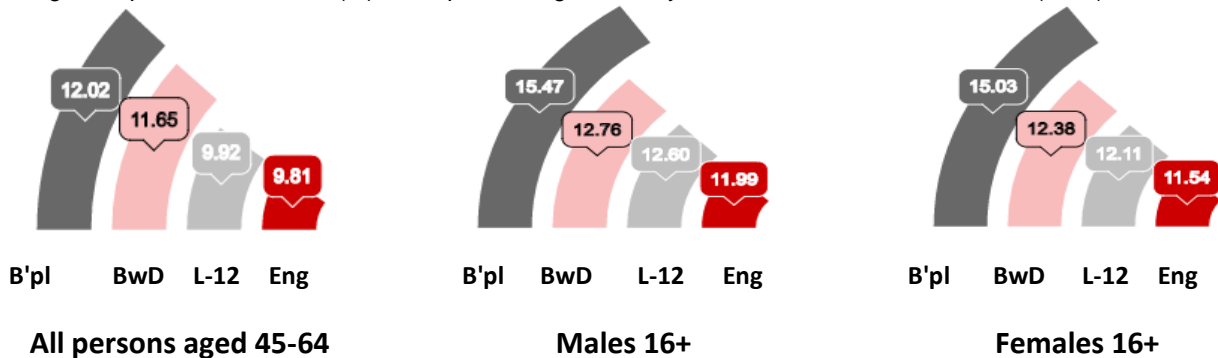


Source: Cancer Research UK, 2017

3.2 Circulatory diseases

Circulatory disease includes heart disease and stroke (also known as cardiovascular disease), with the prevalence of CVD more common in people over 50. The modelled estimates (below) for the three authorities of Lancashire-12, Blackpool, and Blackburn with Darwen all are significantly higher than the comparative rates for England (all persons aged 45-64). When split between the sexes, the three authorities again have percentages higher than England (for 16+).

Figure 3: prevalence of CVD (%) for all persons aged 45-64 years and males and females 16+ (2011)



Source: Public Health England modelled estimates (2011)

Just over 8% of people aged 45-64 in Lancashire-12 stated they had been diagnosed with heart disease, compared to 2% of those aged 16-44 (health behaviours JSNA, 2015).

Mortality from heart disease and stroke is the second leading cause of [premature deaths](#) in the Lancashire-12 area (21% of all deaths, 2013-15). The mortality rates for heart disease and stroke (per 100,000 of all persons) continues to remain significantly higher than England for Lancashire-12 (85.0), Blackburn with Darwen (113.2) and Blackpool (120.3). This identifies potential gaps and opportunities to continue to develop public health messages around the health risks of smoking or physical inactivity for example.

3.3 Liver disease

Liver disease is rising in England, with a rapid increase in cases over the past ten years. There are over 100 types of liver disease in the UK, with at least two million people affected.⁵ The most common types of liver disease are:

- alcohol-related liver disease;
- non-alcoholic fatty liver disease; and
- viral hepatitis.

The rise in liver disease has resulted in an increase in hospital admissions and figures for Lancashire-14 show for all ages, 2,156 people were admitted for [liver disease](#) (2014/15); for alcohol-specific admissions the figure was 7,250.

From the health behaviours JSNA (2015), in Lancashire-12, 5% of those aged 45-54 and 55-64 are classed as harmful (high-risk) drinkers, with 19% classed as hazardous (increasing-risk) drinkers. The highest rates of harmful drinkers are in the older age groups (35-64 years) and these are significantly higher than the 16-24 and 25-34 age groups. For binge drinking, there are significantly more binge drinkers in the 44-64 age groups, compared to the 16-24 and 25-34 groups. This reflects the national picture, which shows older adults are more likely to drink at harmful or hazardous levels.

Mortality rates have increased 400% since 1970 and for those under-65 it has risen by almost 500%. Analysis shows that the highest rate of premature mortality from liver disease occurs in people aged 18-64 years and leads to 62,000 years of working life lost every year. This is just behind ischaemic heart disease (74,000 years) and self-harm (71,000 years).⁶

The premature [mortality rates](#) for Blackpool (44.4 per 100,000 people under-75), Blackburn with Darwen (34.7), and Lancashire-12 (24.7) are statistically significantly higher than the England average (18.0), with the Blackpool rate being the highest in England (2013-15).

With the increase in older adults drinking, further consideration should be made to those who drink at harmful and hazardous levels, particularly those who may be in employment, or those whose drinking may cause future health issues.

3.4 Respiratory diseases

The prevalence of chronic obstructive pulmonary disease (COPD) is continuing to increase across the UK, with a rise of over a quarter in the last decade; this has been attributed to improved diagnosis of the condition and potentially the disease becoming more common.⁷

National evidence shows that people with a COPD diagnosis are mostly over the age of 40, and the risk of developing the condition increases markedly the older a person is. Data from 2012 show 2,228 people (per 100,000 aged 51-60) in the UK were diagnosed with COPD, this increases to 5,385 for the 61-70 age group.⁸ At a local level, 6% of people aged 45-64 in Lancashire-12 stated they had been diagnosed with COPD, compared to 0% of those aged 16-44 (health behaviours JSNA, 2015). For asthma there are higher rates of diagnosis in the younger age groups, with 13% of the 45-64 and 55-64 age groups stating they have asthma.

The death rates for Blackpool (65.8 per 100,000 under-75 years), Blackburn with Darwen (47.6), and Lancashire-12 (41.2) are statistically significantly higher than the average for England (33.1). This equates to a total of 1,731 deaths (909 male, 822 female) for 2013-2015. The trend in under-75 mortality shows decreases across all three areas in Lancashire to 2012-2014, with slight increases between 2012-14 and 2013-15. At a district level in Lancashire-12, only Ribble Valley has a significantly lower rate of COPD mortality compared to England.

3.5 Mental health and wellbeing

Mental health can incorporate a wide range of conditions including anxiety and depression, early onset dementia, bipolar disorder and other affective disorders. These conditions are also closely linked to poorer physical health and negative health behaviours such as smoking or alcohol use. Conversely, people with a long-term physical condition are more likely to experience poor mental health, including depression and anxiety.

3.5.1 Common mental health conditions

The English Longitudinal Study of Ageing (2002-15) has provided a wide range of data and intelligence around ageing, health and functioning in the 50+ population in England. The prevalence of health conditions increases with age, in both men and women, with the exception of depression, which peaks in the 60-64 age group, before decreasing.

While more women than men report depression, the older age groups are less likely to have a diagnosis compared to younger age groups. Poor mental health is also more likely in those people (50+) from lower socioeconomic groups. The table below shows the prevalence rates of depression in those aged 50-64 from the ELSA study.

Table 1: prevalence of depression in males and females, in the 50+ age groups in England (2015)

Age	Males	Females
50-54	7.9%	15.5%
55-59	11.0%	16.5%
60-64	12.7%	16.8%
65-69	12.3%	16.5%
70-74	10.2%	13.7%
75-79	5.7%	10.3%
80+	3.9%	8.2%
All 50+	9.6%	14.3%

Source: English Longitudinal Study of Ageing (2002-15)

From the health behaviours JSNA (2015), approximately 12% of those aged 45-64 stated they had a current mental health condition. Almost a third (30%) of those aged 45-54 and 27% of those aged 55-64 stated they had been diagnosed with depression, anxiety or other mental health condition (at any time), compared to 27% of those aged 16-44.

3.5.2 Young onset dementia

There are many different types of dementia although some are far more common than others, with Alzheimer's disease accounting for the majority of cases, followed by vascular dementia. Young onset dementia (YOD) occurs before the age of 65, with modifiable risk factors including alcohol use, stroke, depression, illicit drug use, low weight and having high blood pressure. Other risk factors include genetic influences, having a low cognitive function, having a learning disability, and anti-psychotic medication use.

Estimates suggest there are 825 people with YOD in the Lancashire-12 area (2014), with a predicted rise to 926 in 2030, if prevalence rates remain static. Potentially there may be up to 500 people under the age of 64 who have YOD but remain undiagnosed.⁹ Evidence indicates that one in four of the 257 people with YOD in Lancashire-12 has a learning disability.

While services are tailored primarily for older people (65+) with dementia, it is important to ensure the working-age population are accommodated adequately. Therefore the recommendations from the [Young Onset Dementia in Lancashire-12](#) needs assessment are relevant to this JSNA and are highlighted at the end of this report in the recommendations section.

3.5.3 Social isolation and loneliness

Social isolation and loneliness are pressing and difficult public health issues, increasingly affecting both individuals and communities. Tens of thousands of households throughout Lancashire-14 are estimated to be directly affected by social isolation and loneliness, causing poor health and wellbeing, and reduced life expectancy; potentially costing health and care services hundreds of millions of pounds annually.

From the health behaviours JSNA (2015) over a half (56%) of 16-24-year-olds in Lancashire-12 report hardly ever feeling isolated from others, significantly lower than 66% of those aged 55-64. There were no differences between the age groups with respect to having companionship and feeling included. However, with regards to feeling close to other people, those aged 45-54 and 55-64 are significantly less likely to state they feel close to other people (both 55%), compared to those aged 16-44 (62%).

The recent [Hidden from view: tackling social isolation and loneliness in Lancashire report and toolkit](#) provides a vision and model of a joined up local system to tackle social isolation and loneliness, together with pointers on an approach to achieve this, with key principles also included. The key recommendations can be found in chapter 6 of the report.

3.5.4 Suicide

Suicide remains a major public health concern and is a devastating event for families and communities. People with a diagnosed mental health condition are at the greatest risk of dying from suicide, including those who are alcoholic, clinically depressed, or have schizophrenia.

Suicide is on average three times more likely in males, compared to females. When looking at age groups, women aged 50-54 and men aged 45-49 are more likely to die from suicide, although rates for males aged 40-44, 50-54 and 55-59 are still high. Research suggests that social and economic factors influence the risk of suicide in women as well as men. This is pertinent with the changes to state pension age and the possibility of having to work for longer and with changes to work.¹⁰

Working to promote good mental health, suicide prevention and harm prevention can help to reduce suicide rates across Lancashire. Social capital and social connectedness underpin the links between individuals and communities and positive mental health. This includes across the wider population, and also for groups who have a higher risk of mental health problems, including people who have a disability, people in lower socioeconomic positions, and those with other health-compromising behaviours such as binge, increased- and higher-risk drinking.

Therefore priorities to support good mental health, resilience, wellbeing and positive coping strategies can have a big impact on reducing health inequalities in the population and allow people to lead happier and healthier lives.

3.6 Diabetes

Diabetes is a major health concern, with type 2 diabetes, accounting for 90% of all cases. While type 1 is treated with insulin, type 2 is amenable to lifestyle changes, including losing weight (if overweight), eating well and exercising. The prevalence of type 2 diabetes continues to increase rapidly, with [estimates to 2035](#) indicating 128,880 people will be living with diabetes in Lancashire-14 (age 16+).

National prevalence figures from the English Longitudinal Study of Ageing (2002-15) for males and females is presented in the table below.

Table 2: prevalence of diabetes in males and females, in the 50+ age groups in England (2015)

Age	Males	Females
50-54	8.4%	2.1%
55-59	9.0%	12.1%
60-64	13.3%	9.7%
65-69	18.4%	11.0%
70-74	18.3%	13.0%
75-79	20.3%	14.4%
80+	17.8%	19.2%
All 50+	14.1%	11.0%

Source: English Longitudinal Study of Ageing (2002-15)

At a local level from the health behaviours JSNA (2015), approximately 14% of those aged 45-64 stated they had been diagnosed with diabetes, compared to 6% of those aged 16-44. A poor diet is a key contributor to diabetes and data from the health behaviours JSNA indicates that the older age groups are less likely to eat fast food/takeaway or consume fizzy drinks compared to those aged 16-34. While poor nutrition is not the only factor, it would suggest that preventative measures across the younger and older age groups would help to reduce the potential for developing the disease. For older people who already had the disease, or were at risk (pre-diabetic), key messages would include effective management of the condition through lifestyle changes.

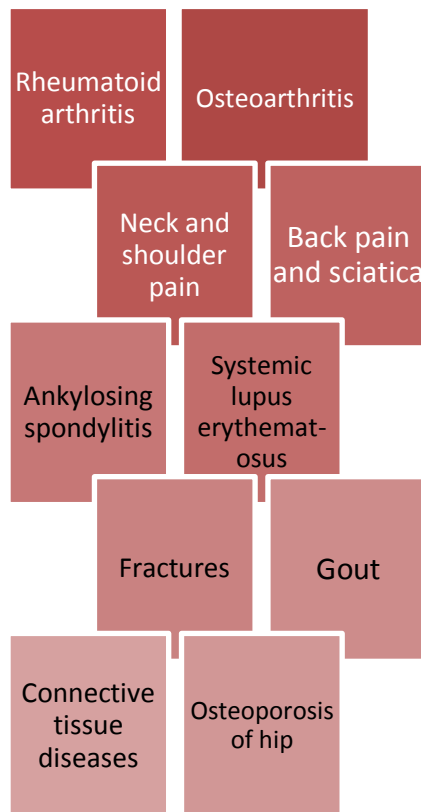
3.7 Musculoskeletal conditions

Musculoskeletal (MSK) conditions are a range of over 200 disorders which affect the joints, bones, muscles and soft tissues and they are more prevalent and severe in later life. MSK conditions do not normally require hospitalisation and are rarely fatal, but they still have a significant social and economic impact and can substantially reduce an individual's quality of life.

It is difficult to produce an accurate prevalence of MSK conditions as the estimates from national research vary widely, although it is estimated that a fifth of the population will consult a GP about a MSK condition each year, while a third of people aged 45 and over have sought treatment for osteoarthritis.¹¹

In Great Britain self-reported rates indicate 16.4 % of males and 22.6% of females (age 45-64) have a longstanding condition of the MSK system.¹² For Lancashire-14 this equates to over 76,200 people aged 45-64.

Figure 4: common musculoskeletal conditions



It is important to appreciate these figures may be under or over-estimated, particularly with the wide differences in the health of residents in the districts in the county.

The economic impact of MSK conditions is huge. They can increase days lost from work, reduce the ability for work in general, and affect the capacity for work at an older age.

Estimates indicate MSK conditions account for 41% of the total prevalence of all work-related ill health and results in 8.8 million lost working days per year (2015/16).¹³

3.7.1 Risk factors for MSK conditions

Evidence suggests agriculture, forestry and fishing, construction, transportation and storage, and human health and social work have significantly higher rates of work-related MSK conditions in Great Britain (compared to other industries) and across skilled occupations and process and machine operatives. Specifically, areas of increased risk include manual handling, lifting and carrying, cutting (as in agriculture), stooping, bending, and repetitive movement.¹⁴

Ageing is also a factor for work-related MSK conditions, with both men and women aged 45-54 and 55+ having significantly higher prevalence rates than those aged 16-34. These differences may in part be attributable to three musculoskeletal changes:


- a reduction in joint mobility;
- a decrease in muscular strength; and
- the slowing of reaction and movement times.

Other risk factors for the development of MSK and osteoarthritis in particular include being female, genetic factors and previous joint injury. However, the largest modifiable risk factors are obesity and a lack of physical activity.

An ageing population, alongside rising levels of obesity and physical inactivity, is expected to increase the numbers of people living with painful musculoskeletal conditions. It is important to recognise that as obesity levels increase across the population it is more likely that people will be presenting with MSK conditions much earlier in life.

3.8 Menopause

The menopause is marked by the cessation of a woman's periods and the ability to get pregnant naturally. It is caused by a change in the balance of the body's hormones, which occurs as a woman ages. Typically the menopause occurs between the ages of 45–58 (average age 51).¹⁵ Approximately two-thirds of women aged 50-59 are in employment, so the menopause can have a significant effect on the working lives of women. This can include symptoms such as hot flushes and night sweats, to insomnia, tiredness, aching muscles and joints and anxiety and depression.



145,379
women in
Lancashire-14 are
aged between 45-58

Managing the symptoms can reduce absenteeism, maximise productivity and ensure the working environment is meeting the needs of menopausal women. Evidence suggests raising awareness of the menopause (for both employees and managers), supporting flexible working hours, attention to workplace temperature and ventilation and ensuring access to information and sources of support at work are important considerations. Where reasonable adjustments are made it can increase employee loyalty and participation in the workforce.¹⁶

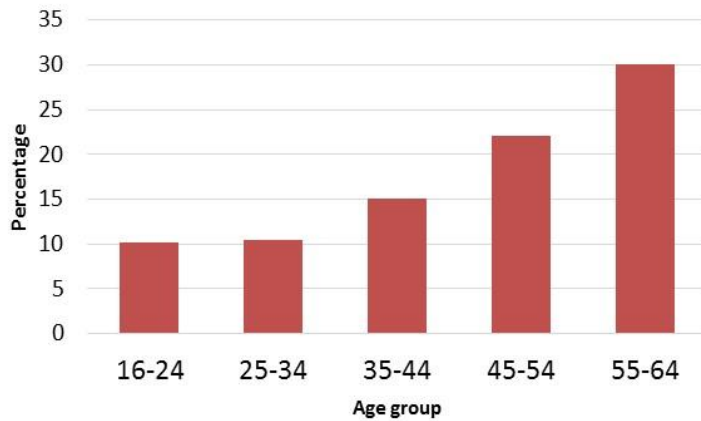
4. Caring responsibilities

Social care provides help and support to individuals, allowing them to lead independent lives, or improving their quality of life. A large proportion of social care provision comes from local authorities, with many individuals providing unpaid care. A growing demand on social care budgets with an ageing population may mean more people are relying on friends and family to provide care, or help with activities of daily life.

The Health Survey for England (2015) found that 16% of all adults in the north west provided help or support to another person due to a long-term physical or mental ill-health issue, a disability or problems relating to old age (excluding help provided in a professional capacity), compared to England (18%).

Breaking this down by age, caring responsibilities increase as a person ages, with 30% of those aged 55-64 providing help or support, compared to 10% of those aged 16-24.

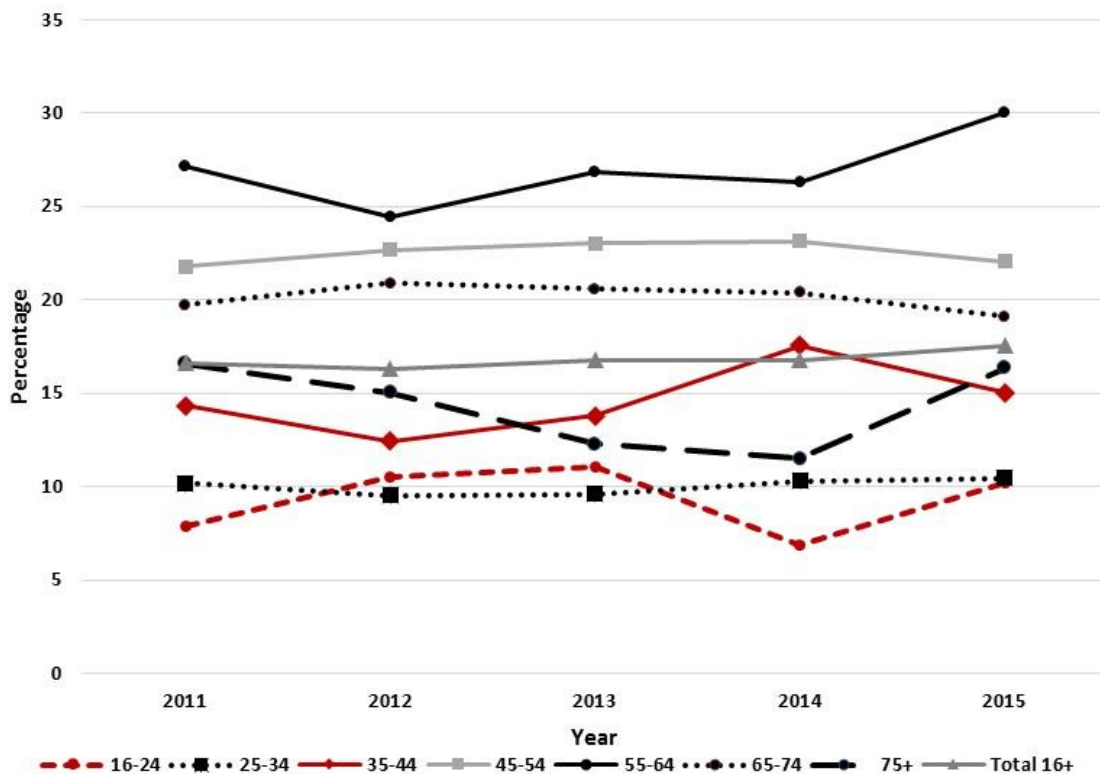
Figure 5: adults (16+) providing unpaid help or support in England (2015)



Source: Health Survey for England (2015)

Looking at the five-year trend (2011-2015), while there have been slight increases and decreases, overall the percentages have remained fairly constant, with those aged 55-64 providing the most unpaid help or support. The greatest difference unsurprisingly was between the 55-64 and 16-24 age groups.

Figure 6: adults (16+) providing unpaid help or support in England (2011-2015)



Source: Health Survey for England (2015)

Although past or current caring responsibilities may have meant people had developed additional skills, they may also have created a sense of isolation and loss of contact with the working world. Current caring responsibilities may mean people can only work certain hours or are looking for jobs with flexible working hours (see also the [flexible work schedules](#) report), which may be problematic to fit in with existing schedules. This can easily lead to additional issues around finances, housing and other commitments.

5. Developing the 50+ workforce

Undoubtedly people working at/to an older age is necessary to offset the economic impact of an increasing ageing population. However, understanding the impact of disease and illness and what factors make it easier or more difficult for those with long-term conditions or health issues to access work or stay in work is less well understood, but equally as important.

Working at an older age can confer many psychological benefits (if this is a course of action that a person chooses); where there is a perceived lack of choice or having a situation where retirement is neither desired nor planned can result in negative health outcomes.

The psychological benefits to staying in work may include a sense of purpose, social engagement and involvement, and improved general mental health functioning. Conversely, continuing to work beyond the normal retirement age may produce an exacerbation of existing health conditions, difficulties in keeping up with workplace advances, depression, and reduced opportunities (particularly for physical jobs) as physical functioning declines as a person ages.¹⁷

5.1 Financial circumstances

Financial factors can play a big role in the life planning of older adults, which differ greatly from the younger working-age population. These can include the affordability of retirement, pension provision, benefits entitlement, housing tenure, and commitments such as mortgages and loans, and caring for dependents.

Across all of the working-age population there has been a reduction in the prevalence of low income in the past twenty years. However, many people in the UK are still classed as 'households below average income' and a recent report from the Joseph Rowntree Foundation suggests 22% of the population in the north-west are living in poverty (after housing costs). Looking at age-specific data, 19% of those aged 45-54 are in poverty (after housing costs) in 2014/15, an increase from 15% in

2004/05. For the 55-64 age group the figures are 19% (2014/15) an increase from 17% in 2004/05.¹⁸

Not surprisingly, those people who are classified as 'workless, other inactive' are more likely to be in poverty, compared to other work status groups. Those least likely to be in poverty are couples where one is in full time work and one is in part time work.¹⁹ Those in the more deprived quintiles are more likely to be considered in poverty, with 52% of workless households in the bottom quintile, compared to 8% in the top quintile.²⁰

5.2 Barriers to working

Health issues can be one of the biggest barriers to working or staying in work for those who are over-50, with concerns as to whether work will exacerbate existing medical conditions, or impede recovery.

Other barriers can include job expectations, perceived individual capabilities and skills to undertake a particular role, a lack of formal qualifications and less access to training. Age discrimination and negative stereotypes may also play a role in the employment prospects of older workers and should not be dismissed.

A work-based approach to training is likely to have beneficial effects on the health of those who may not have previously engaged in learning/training. While this can help narrow inequalities between those who are in work, it can also widen the health inequalities between those in work and those out of work.²¹

Evidence suggests that public health policy is needed to aid the design of jobs that better accommodate older workers, particularly those with health limitations. While some limitations can reduce the potential workplaces available, these can be overcome with thoughtful intervention.²² This policy shift will be needed to ensure that people are afforded the opportunity to work beyond what is considered a normal retirement age (state pension age), and also to support the economy in filling job vacancies.

6. Conclusions

There are many benefits to having an older workforce, including having a wide range of skills and experiences, the capacity to transfer skills between workers, improved staff morale and reduced staff turnover.²³ While it is less likely people in this age group have younger dependants, many will now have other caring responsibilities in the form of older parents/relatives or partners, which may impact on their capacity to look after their own health.

The Marmot Review, 'Fair Society, Healthy Lives' stresses the following priority objectives around employment, which can be applied to the 50+ population:

- improving access to good jobs and reducing long-term unemployment;
- making it easier for people who are disadvantaged in the labour market to obtain and keep work; and
- improve the quality of jobs across the social gradient ²⁴

Therefore, flexible and adaptable work can also allow older staff to plan effectively for their own retirement and handover of skills/experience to suit the employer and employee.

Working beyond 65 is not covered in this report, but it is important to be aware of the consequences and other outcomes of this, as many residents in Lancashire-14 are likely to continue to work beyond this age.

Effective planning to maximise work and other opportunities (including volunteering) for older workers needs additional intelligence on the epidemiology of ageing and employment outcomes, particularly around long-term conditions such as MSK. Due to the changing demographics of the population, further areas for consideration are captured in the recommendations from the [final WAP JSNA](#) report; other potential areas for exploration include:

- How often do 50+ workers struggle to cope at work?
- How often do they quit employment due to medical reasons and what are these reasons?
- What are the levels of sickness absence in older workers and what are the causes?
- Will an older population find employment easy to achieve if they have left previous employment due to ill health?
- What support systems need to be in place to allow workers the opportunities to work at an older age?

A reduction in premature mortality rates, incidence and prevalence of long-term conditions, and narrowing of the health inequalities gap is a good indicator that the recommendations are addressing the identified priorities, although it may take time for these to filter through and have an impact.

7. Appendices

7.1 Appendix one – population projections for the working-age population in the Lancashire-14 area.

The table below shows the working-age population (16-64) and the percentage of those in the 50-64 age groups

Table 3: 2039 population projection breakdown for Lancashire and districts (mid-2014 population estimates)

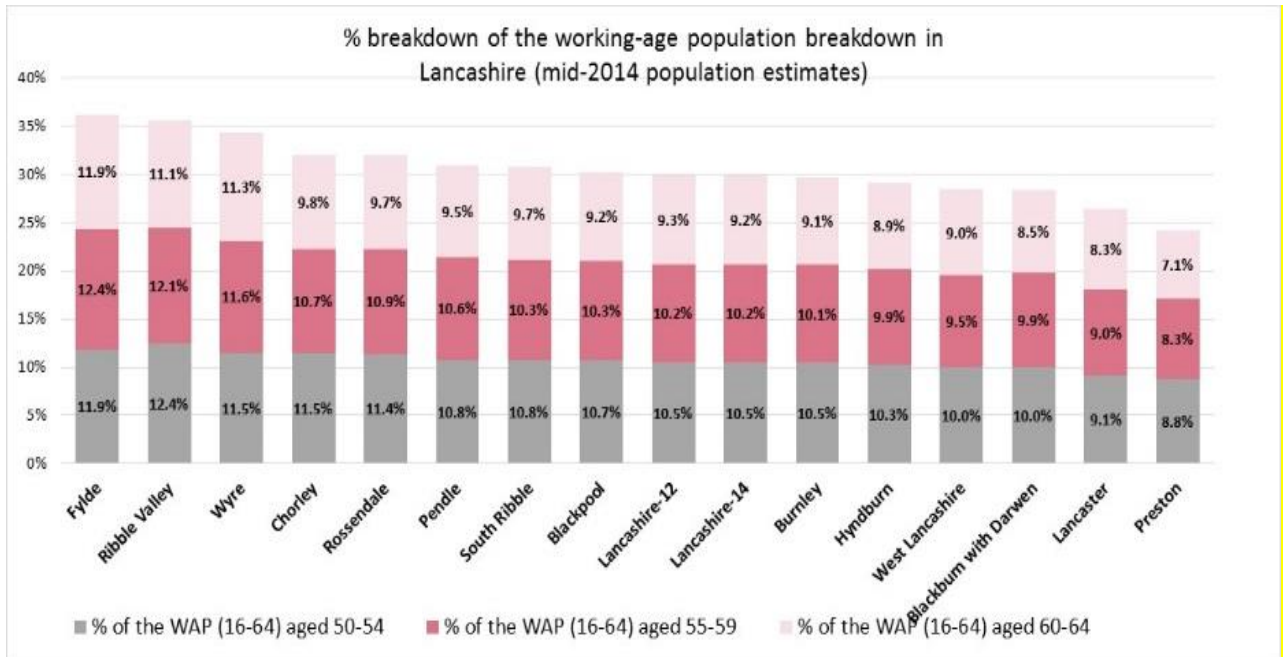
Area	All persons all ages	All working age 16 to 64	Ages 50-64	% of the WAP aged 50-64
Blackburn with Darwen	144,000	83,200	23,600	28.4%
Blackpool	139,800	78,600	23,700	30.2%
Burnley	87,300	49,700	14,700	29.6%
Chorley	131,900	73,700	23,600	32.0%
Fylde	84,200	41,100	14,900	36.3%
Hyndburn	78,300	43,600	12,700	29.1%
Lancaster	154,500	90,500	23,800	26.3%
Pendle	91,700	51,700	16,000	30.9%
Preston	145,600	89,100	21,500	24.1%
Ribble Valley	61,300	31,400	11,200	35.7%
Rosendale	74,900	42,200	13,500	32.0%
South Ribble	112,700	61,100	18,800	30.8%
West Lancashire	116,400	63,300	18,000	28.4%
Wyre	115,800	58,500	20,100	34.4%
Lancashire-12	1,254,600	695,900	208,800	30.0%
Lancashire-14	1,538,400	857,700	256,100	29.9%
England				

Source: [Office for National Statistics](#)

The chart below shows the percentage breakdown of the 50-64 age group in 2039 by district. Additional population projections can be viewed [here](#).

Working-age population 50-64 years

Figure 7: percentage breakdown of the working age population 50-64 projections in 2039



8. References

Please note, due to difficulties in keeping links up to date in our documents, these references are not all hyperlinked, apologies for any inconvenience this may cause.

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