



Lifestyle behaviours

Supporting evidence and key findings for the
working-age population JSNA 2017

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1. Overview

This report focuses on the health behaviours and lifestyle factors that can influence the health and wellbeing of the working-age population (WAP). It complements the WAP joint strategic needs assessment (JSNA) final report. It uses a wide range of data and resources that can be viewed on the publications section of the [Lancashire Insight](#) web pages. The rise in the state pension age will change the demographic of the 'working-age population', but for the purposes of this JSNA, the focus is on those aged 16-64.

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. Where possible, any 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. Analysis from the [health behaviours JSNA](#) is also presented for the 16-64 age group, with other national/local data and evidence where appropriate (identified in the text for clarification).*

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

2. Background information

There is renewed emphasis on preventing ill health and improving the wider health of the WAP, which remains poor in many areas across Lancashire. As a person ages they are more at risk of developing various health conditions, many linked to lifestyle and other factors, including cellular damage, genetic risk and the impact of living/working conditions.

Predicted population changes for Lancashire indicate that the older population (65+) will continue to increase, and fewer young people will be entering the workforce. This gap will not be filled through immigration and migration alone and with rises to state pension age, keeping the WAP healthy and productive is vital.

* The age group brackets for the health behaviours JSNA are 16-24, 25-34, 35-44, 45-54 and 55-64.

3. Health and lifestyle

This report will focus on several lifestyle behaviours in the WAP including:

- alcohol consumption;
- healthy eating;
- physical activity;
- substance use; and
- smoking.

While there are other lifestyle factors that can have an impact on a person's health and wellbeing, such as sunbed use or sexual behaviour, the ones above have been included as they are linked to many health conditions and data is more readily available.

3.1 Alcohol consumption

Over-consumption of alcohol can lead to irreversible liver damage including cirrhosis and alcoholic hepatitis. It can also substantially increase the risk of mouth and throat cancers, as well as high blood pressure and heart problems. It can also exacerbate or contribute to poor mental health. Aside from the health risks, alcohol consumption can lead to difficulties around social and family relationships, crime, housing, and employment. It can also be linked to deprivation, poverty and a chaotic lifestyle.

Figures suggest a quarter of the UK population drink more than the recommended guidelines and are considered hazardous drinkers (increasing risk), while 10% are considered harmful drinkers (high risk). Between the two groups they account for three-quarters of alcohol sales.¹

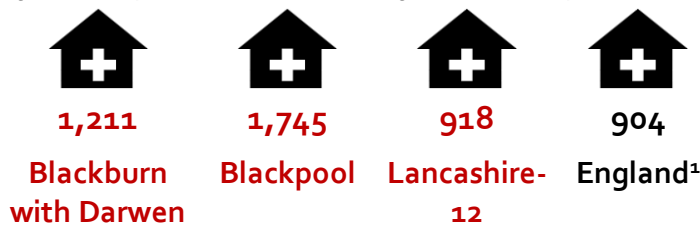
Nationally alcohol accounts for three-quarters of deaths due to liver disease and is estimated to cost the NHS £3.5 billion per annum.² The rise in harmful and hazardous drinking levels has been linked to increased affordability, promotion and availability of alcohol.³

3.1.1 Key findings for Lancashire

Reducing harmful drinking is one of seven priority areas for Public Health England and national [alcohol indicators](#) show there are many areas that require improvement across Lancashire.

Hospital admissions data show significantly more people (aged 40-64) are admitted to hospital for alcohol-related conditions in Blackburn with Darwen and Blackpool, compared to England. The rate for Lancashire-12 is similar.

Figure 1: hospital admissions adults aged 40-64, rate per 100,000, 2015-16



¹ Admission to hospital for alcohol-related conditions (narrow)

Source: Public Health England Local Alcohol Profiles

Alongside the health consequences, people who are alcoholic may often be reliant on the benefit system due to issues around maintaining employment. The data for 2016 indicate there are significantly more claimants of benefits due to alcoholism in Blackpool (572.2 per 100,000), Blackburn with Darwen (334.4) and Lancashire-12 (194.2) compared to England (132.8).[†]

3.1.2 Health behaviours JSNA findings

Reflecting the trends for England, the highest self-reported rates of alcohol consumption (any amount) are amongst those aged 45-54 (74%) and 55-64 (73%), while the lowest rate is among those aged 16-24 (68%). Four per cent of those aged 16-64 are classed as harmful (high-risk drinkers), while 14% are hazardous (increasing risk). Breaking this down by age group, the highest percentage of high-risk drinkers is in the 45-64 and 55-64 age brackets (both 5% respectively).

Looking at binge drinking 9% of those aged 35-44, 9% of those aged 45-54 years and 8% of those aged 55-64 state they binge drink two to four times a week or daily/almost daily. For those aged 16-24 the figure is 2%, and 3% for 25-34 years. There are significantly more binge drinkers in the 35-64 age groups, compared to those aged 16-34.

3.2 Substance use

Substance use can take many forms including using new psychoactive substances, misusing prescribed medication, and cannabis or opiate use. Substance use is closely linked to deprivation, poverty and a chaotic lifestyle, alongside other factors such as poor mental health, having a learning disability or difficulty, experiencing sexual exploitation, and alcohol use. The wider determinants of health also play a part, such as being homeless or unemployed, which can increase a person's risk/vulnerability to substance use. The social and economic cost of drug supply has

[†] Males aged 16-64, females aged 16-61

been estimated to be £10.7 billion a year, of which over half is attributed to drug-related acquisitive crime.⁴

3.2.1 Key findings for Lancashire

Indicators around substance use show 8.4 persons per 1,000, aged 15-64 are estimated to be opiate and/or crack users in Lancashire-12, in line with the national estimate (8.4). Blackburn with Darwen (14.7) and Blackpool (20.0) have significantly higher levels of opiate and/or crack users than England (2011/12).

The proportion of successful drug treatment programmes for opiate users is significantly better for Lancashire-12 (10.7%) when compared to England (6.7%). The proportions are similar for Blackburn with Darwen (6.3%) and Blackpool (6.0%) (2015).

3.2.2 Health behaviours JSNA findings

Respondents to the health behaviours questionnaire were asked "Have you used drugs, other than those required for medical reasons, in the last 12 months?" with approximately 7% of those aged 16-64 answering yes. Breaking this down further, those aged 16-24 and 25-34 were significantly more likely to use drugs occasionally when compared to the older groups. The proportion of those who used drugs weekly or more than weekly was broadly similar across the age brackets, with the highest percentage among those aged 25-34 (3%).

Figure 2: proportion of respondents who had used drugs in the previous 12 months, 2015

16-64	16-24	25-34	35-44	45-54	55-64
7%	11%	11%	8%	4%	2%

Source: health behaviours JSNA, 2015

Of those who use drugs, cannabis (including marijuana and hash) is the most commonly used, with 91% of those in 55-64 age bracket using it, followed by 81% of those aged 45-54 and 80% of those aged 16-24. Cocaine/crack (33%) and ecstasy/MDMA (23%) also have relatively high usage rates for all drug users aged 16-64. The data show higher rates of use of new psychoactive substances and poppers among the younger age groups (16-24 and 25-34), although the differences compared to the older age groups are not significant.

3.3 Healthy eating

A poor diet is a risk factor for many major health conditions including some cancers, coronary heart disease, obesity and diabetes. The evidence also suggests people who do not eat well are more likely to be physically inactive, smoke, and/or drink.

Healthy eating is less likely in those who are struggling financially, those with a disability (including mental health issues), younger people and those who are obese or very underweight. Poverty also has an impact with deprived and socially disadvantaged people and households having poorer dietary-related health outcomes and behaviour, compared to more affluent individuals/households.⁵

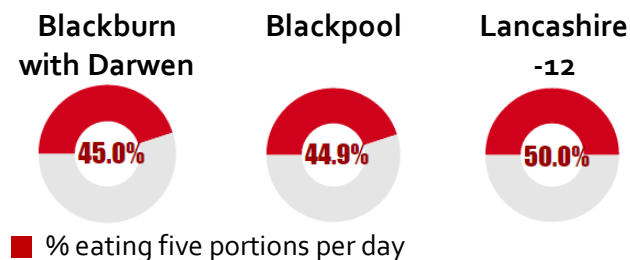
Income is not the only factor which can influence healthy eating. Cooking and storage facilities can be problematic for some households, and the cost of gas/electricity can also prohibit consumption of healthy food. In these situations foods that are convenient are more likely to be eaten – this includes processed foods and takeaway/fast food. A perceived or real lack of time to shop, prepare and cook healthily can also impact on a nutritious diet. Other barriers to healthy eating include:

- lack of knowledge or education surrounding healthy eating;
- lack of knowledge or education around food preparation;
- poor accessibility to affordable food – 'food deserts';
- inconsistent or unclear food labelling; and
- the marketing of high fat high sugar foods to children.^{6,7}

3.3.1 Key findings for Lancashire

Public Health England collates data around healthy eating and nutrition across a range of [lifestyle indicators](#). One of these includes fruit and vegetable consumption, and shows the percentage of adults (16+) meeting the recommended five portions per day is significantly lower in the three authorities when compared to England (52.3%).

Figure 3: percentage of adults meeting '5 a day' and fruit and vegetable consumption, 2015



Source: Public Health England Outcomes Framework, 2015

Adults (16+) in Blackpool and Blackburn with Darwen eat significantly fewer portions of fruit daily than England (2.51), while for Lancashire-12 there is no difference. For

portions of vegetables consumed, adults (16+) in all three authorities eat significantly fewer compared to England (2.27). Further details are available in the table below.

Table 1: portions of fruit and vegetables consumed per day, 2015

Area	Fruit	Veg
Blackburn with Darwen	2.22	2.03
Blackpool	2.26	2.01
Lancashire-12	2.50	2.16
England	2.51	2.27

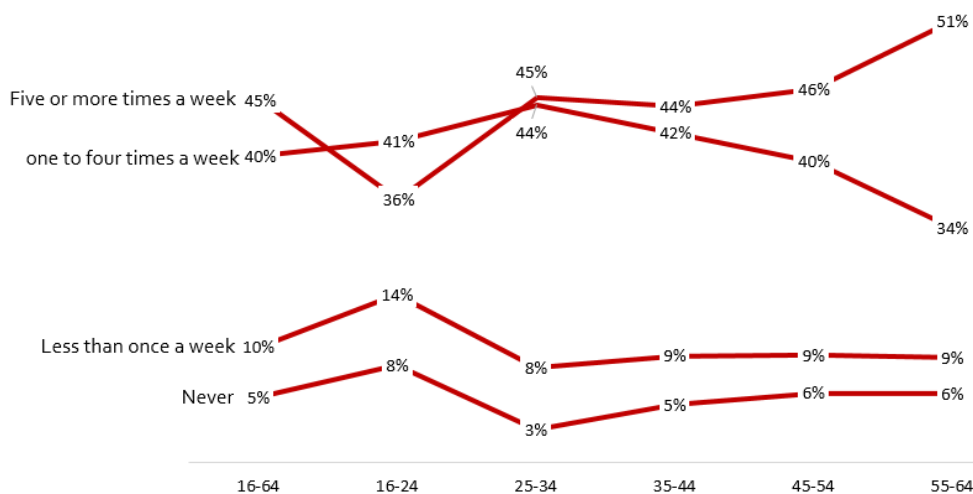
Source: Public Health England Outcomes Framework, 2015

Additional analysis from Public Health England estimates there are 1,741 fast food outlets in Lancashire-14. This equates to a crude rate of 121.9 (per 100,000 of the population) for Lancashire-12, 128.1 for Blackburn with Darwen and 192.9 for Blackpool; all three are significantly above the England rate (87.8) (2016). Easy access to low-quality food can contribute to the obesogenic environment, particularly in more deprived areas.⁸

3.3.2 Health behaviours JSNA findings

Healthy eating is significantly more likely in the older age groups, with 28% of 55-64s eating five or more portions of fruit/vegetables per day. In comparison only 19% of those aged 16-24 and 25-34 eat five or more. Almost a quarter those aged 16-24 eat one or fewer portions per day compared to 12% of the 55-64 group. Looking at meal preparation those aged 16-24 are significantly less likely to cook a meal from scratch with basic ingredients: 22% indicate that they did this 'never' or 'less than once a week'.

Figure 4: respondents who cook/prepare meals for their family/household by age group, 2015



Source: health behaviours JSNA, 2015

Fizzy and soft drink consumption (excluding sugar free items) is significantly more likely in the younger age groups. Just under a third (29%) of 16-24s and 18% of 25-34s consume these products six or more times a week, in comparison with 6% of 55-64s. Conversely, the older age groups (45-54 and 55-64) are significantly more likely to say they rarely or never consume fizzy drinks.

3.4 Healthy weight

Excess weight is the biggest risk factor for diabetes, hypertension, cardiac diseases and strokes, and for some of the more common cancers, including colon cancer. It also can trigger or exacerbate other conditions, such as musculoskeletal issues, with joints such as the knees, and the back particularly affected. There are also psychological issues associate with excess weight such as depression, low self-esteem, and social exclusion.

The cost of obesity to the UK's National Health Service is estimated at £5.5 billion per year, however it is recognised that this is most likely underestimated.⁹ Other economic costs include benefit payments, with research from the Department of Health indicating working-age obese people may be 15-20% less likely to be in employment than non-obese, with the associated issues unemployment or economic inactivity brings.¹⁰

Excess weight can have a big impact in the workplace, affecting both employees and employers. Within the workplace obese workers may be perceived as lazy or less productive, which potentially can lead to prejudice and discrimination. Evidence also indicates obese people take an extra four days of sick leave per year, compared to their non-obese colleagues.¹¹

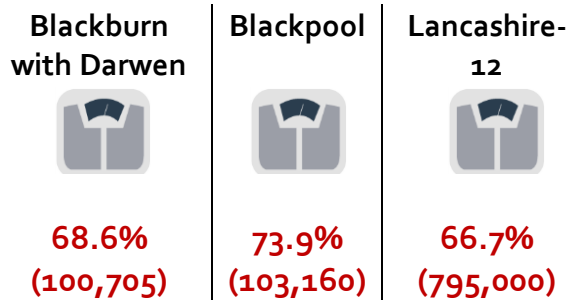
There are also issues around the provision of suitable equipment such as chairs, ladders, workspaces and personal protective kit for the obese individual, while other concerns focus on whether obese people are excluded from certain jobs, or find some roles more difficult due to their weight.

All ages can experience excess weight, with no one group more likely to be obese or overweight. Young adults (aged 18-25) may be at risk of obesity due to changes in their lifestyles such as moving away from home, gaining more independence, working, living with partners, getting married and/or becoming parents.¹² Older adults may experience weight gain due to other factors such as ill health, which can result in inactivity.

3.4.1 Key findings for Lancashire

Excess weight in adults is defined as those adults (aged 16+) who are recorded to have a BMI greater than or equal to 25kg/m² (overweight including obese).

Figure 5: proportion of excess weight in adults 16+



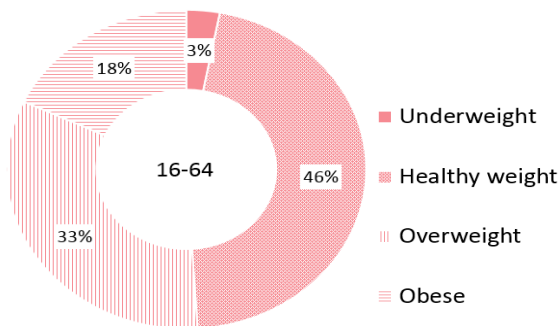
The latest figures from Public Health England indicate all three districts have significantly higher proportions of adults (16+) who are overweight or obese when compared to England (64.8%). This equates to almost 999,000 people across Lancashire-14.

Source: Public Health England Outcomes Framework (Jan-13 to Jan-16)

3.4.2 Health behaviours JSNA findings

Measures of self-reported weight indicate that over half of adults aged 16-64 are obese or overweight, lower than the national figures. This potentially may be due to reporting bias, where excess weight is unintentionally or intentionally underreported.

Figure 6: self-reported weight 16-64



Breaking this down further, significantly fewer 16-24s (31%) are overweight or obese compared to the other age groups. Sixty per cent of both the 45-54 and 55-64 age groups are overweight or obese, significantly higher compared to those aged 16-24 and 25-34.

Significantly more 16-24 year olds (7%) are classed as underweight compared to the other age groups, with 2% of 25-34s and 35-44s, and 1% of 45-54s and 55-64s being underweight.

3.5 Physical activity

Physical inactivity is a major risk factor for many health conditions, including cardiovascular disease, colon and breast cancers, cerebrovascular disease, type 2 diabetes and osteoporosis. People who are physically active have a 20-35% lower risk of CVD, CHD and stroke compared to those who have a sedentary lifestyle.

Although there are existing local, regional and national efforts to increase physical activity levels across the population, participation among children and adults remains low. Evidence shows even small increases in physical activity, such as walking and cycling, results in benefits to health and can reduce costs to the NHS, which is estimated to cost almost £1bn per year across the UK.¹³

There can be many barriers to physical activity, which may include time and cost restrictions, a lack of motivation and/or a lack of sporting facilities or suitable areas for activity.¹⁴ While addressing barriers is important, building on motivating factors will also encourage more physical activity levels. These may include proximity to walking paths/trails, even pavements, clean streets and neighbourhoods, seating facilities, and access to recreational services/parks.¹⁵



3.5.1 Key findings for Lancashire

Activity levels vary across the county and the proportion of adults (16+) walking at least five times a week are significantly lower in Blackburn with Darwen (45.3%) and Lancashire-12 (48.9%), when compared to England (50.6%). While Blackpool is similar (51.4%), this still means that just under half of the population are walking less than five times a week (2014/15).¹⁶

Figure 7: % of physically inactive adults (16+), 2014/15

35.6%	37.6%	37.1%
Blackburn with Darwen	Blackpool	Lancashire-12

Across the three authorities, the proportion of physically inactive adults (aged 16+) is significantly worse than England (28.7%) (2014/15).

Source: Public Health England, 2014/15

3.5.2 Health behaviours JSNA findings

Overall, more respondents are meeting guidelines for moderate intensity activity, compared to vigorous activity.

Two-thirds of respondents across the 25-64 age brackets state they are achieving the recommended two and a half hour or more of moderate intensity activity per week. For 16-24s, this is higher at 75%, although it is not significantly different.

Figure 8: % of adults 16-64 meeting activity guidelines

68%	42%
are meeting guidelines for moderate activity	are meeting guidelines for vigorous activity

Source: health behaviours JSNA, 2015

Levels of activity (moderate and vigorous) decrease with age, with the 16-24 and 25-34 age groups are significantly more likely to be physically active compared to those in the 35-64 age brackets.

3.6 Smoking and tobacco use

Smoking and tobacco use is the biggest cause of illness and premature death in the UK from a range of conditions including cancer and heart disease, with Cancer Research UK estimating 86% of lung cancer cases are caused by smoking tobacco.

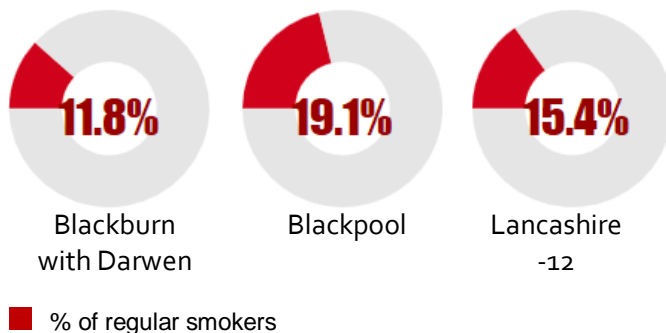
Tobacco presents a significant economic burden: from costs of treating tobacco-related illness, to reduced productivity, absenteeism, higher numbers of accidents and damage to buildings, and environmental harm, including cigarette detritus. Public Health England estimates 11 million work days are lost each year due to smoking-related sick days, while research from the British Heart Foundation estimates that sick leave for smokers and smoking breaks are estimated to cost UK businesses £8.7billion per year.¹⁷

Smoking increases an individual's risk of developing care needs and contributes to the rising social care budgets of local authorities, with research suggesting smoking-related ill health costs £1.4 billion per year in England (for local authorities and people who self-funded their care), with smokers likely to need care on average four years earlier than non-smokers.¹⁸ Evidence indicates the total burden caused by tobacco products outweighs any economic benefit from their manufacture and sale.¹⁹

3.6.1 Key findings for Lancashire

National evidence shows those in manual occupations are more likely to smoke, compared to those in higher socioeconomic roles. The prevalence rates (all smokers aged 18+ in routine/manual occupations) in Blackburn with Darwen and Blackpool are significantly higher than England, with Lancashire-12 having a similar rate.²⁰

Figure 9: proportion of regular smokers aged 16-17 (2009-12)



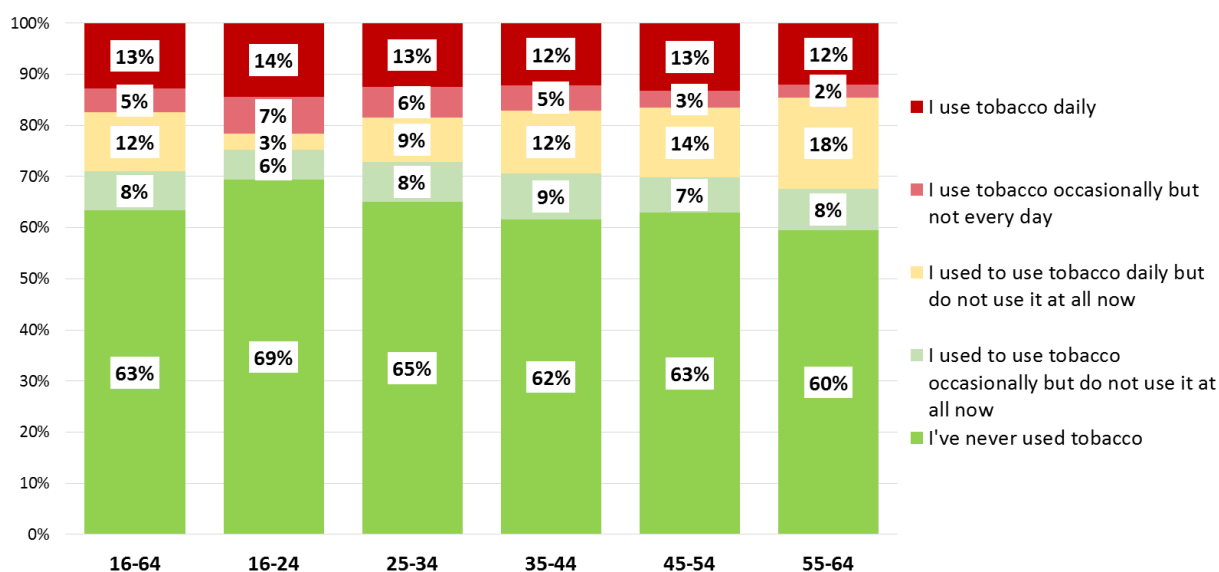
Although the percentage of regular smoking in young people aged 16-17 is higher in Blackpool and Lancashire-12, compared to England (14.7%), these figures are not significantly different. Blackburn with Darwen is also similar (based on modelled estimates).

Source: Public Health England Local Tobacco Profiles

3.6.2 Health behaviours JSNA findings

There are significantly higher rates of people aged 16-24 who state they have never used tobacco compared to those aged 35-64, while the younger age groups (16-24 and 25-34) are more likely to say they use tobacco occasionally or daily when compared to the older groups. Smoking cessation rates are significantly higher in those aged 55-64s compared to the other age groups, with 18% stating they used to smoke daily, but have now stopped.

Figure 10: tobacco use in the 16-64 population in Lancashire-12, 2015



Source: health behaviours JSNA, 2015

Across the 16-64 age group, manufactured and hand-rolled cigarettes are the most popular form of tobacco use (58% and 52% respectively). Chewing tobacco (1%), pipe smoking (1%) and bidis (<0.5%) are rarely used.[‡] Shisha/water pipe use is mainly restricted to the 16-24 group, with 5% stating they currently use these products.

Analysis of e-cigarette use shows that the majority (88%) of the 16-64 population have never used one. Daily use across all age groups is low (3%), with 25-34s having the highest rate (4%). Rates of occasional use are also very low (3%). These are similar to figures for England collated by the Office for National Statistics (2015), which indicate 4.5% of all people 16+ are current e-cigarette users.²¹ There is limited data and research around the use and effects of e-cigarettes, therefore, this may be an area of further investigation/interest to partners in Lancashire.

[‡] Bidis are small hand-rolled cigarettes made from tobacco and plant leaves native to Asia.

4. Conclusions

The health of residents across Lancashire varies widely and these differences in health can be attributed to the variations in lifestyle behaviours and other factors, such as age and genetics. Health often deteriorates as a person ages and while it isn't a natural consequence of ageing, it is more likely following a lifestyle of drinking, smoking, inactivity and poor nutrition.

The identified recommendations in the [WAP final report](#) are based on the available data and intelligence for the working-age population in Lancashire-12, Blackburn with Darwen and Blackpool. They fit around the areas of healthy workplaces, healthy spaces and healthy people.

The recommendations have been based on evidence of what works, around guidance developed by the National Institute for Health and Care Excellence ([NICE](#)) and other Lancashire joint strategic needs assessments. This JSNA also links into the Public Health England report 'From evidence into action: opportunities to protect and improve the nation's health', which identifies positive change and promoting health, rather than just treating illness. It advocates the following measures to develop people's health:

- the application of behavioural science in the digital age;
- place-based approaches;
- develop [NHS preventative services](#);
- transparency, allowing everyone to access information on performance and/or need and the evidence on 'what works';
- the contribution of employers in improving people's mental and physical health; and
- improve health through the application of the concept of wellness ²²

The measure of success of any recommendations will observe an impact on health and health inequalities, with reductions in premature mortality rates, reduced incidence and prevalence of long-term conditions, and self-reported rates of poor health.

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

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