Prevention Matters:

Shropshire's Prevention Framework and System Action Plan

Working with and supporting people in Shropshire to live longer and healthier lives by taking a preventative approach to improving health and wellbeing outcomes.

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Foreword

Foreword from Cllr Motley and Simon Whitehouse as HWBB Chairs

The Health and Wellbeing Board (HWBB) members acknowledge their individual organisational and our collective shared responsibility, to focus on prevention and early intervention to achieve sustainable and improved outcomes and enhance for people in Shropshire, while seeking to address variation in health and wellbeing outcomes.

This document provides our collective commitment to do just this, and the framework agrees our approach. The action plan outlines where our joined-up approach to prevention will accelerate and enhance our current work, recognising the opportunities in working together, reducing duplication and adding value for our people and communities.

Endorsement from all Partners through HWBB and SHIPP (tbc November 2023)

This framework and action plan adds detail to local and national high level strategy documents including:

STW NHS Integrated Care Strategy (2022) The Shropshire Plan (2022) , Priority for Shropshire's Health and Well Being Board – Healthy People (2022) Shropshire Council People Making a Difference (2022), Statement of Intent – joint vision for a model of integration across CYP Early Help/Prevention, Health Inequalities Plans and Health in All Approach, Targeted Shropshire Together Programmes and Major Conditions Strategy, NHS England Prevention Programme

Introduction and Overview

Evidence shows that **prevention is better than cure** leading to improved outcomes for people, better demand management on services and long-term cost effectiveness for commissioners.

Our ambitious approach to prevention builds on the effective work already established across the County and the Integrated Care System, recognising that all key partners, communities and individuals have a role in improving the quality of lives and health of our population.

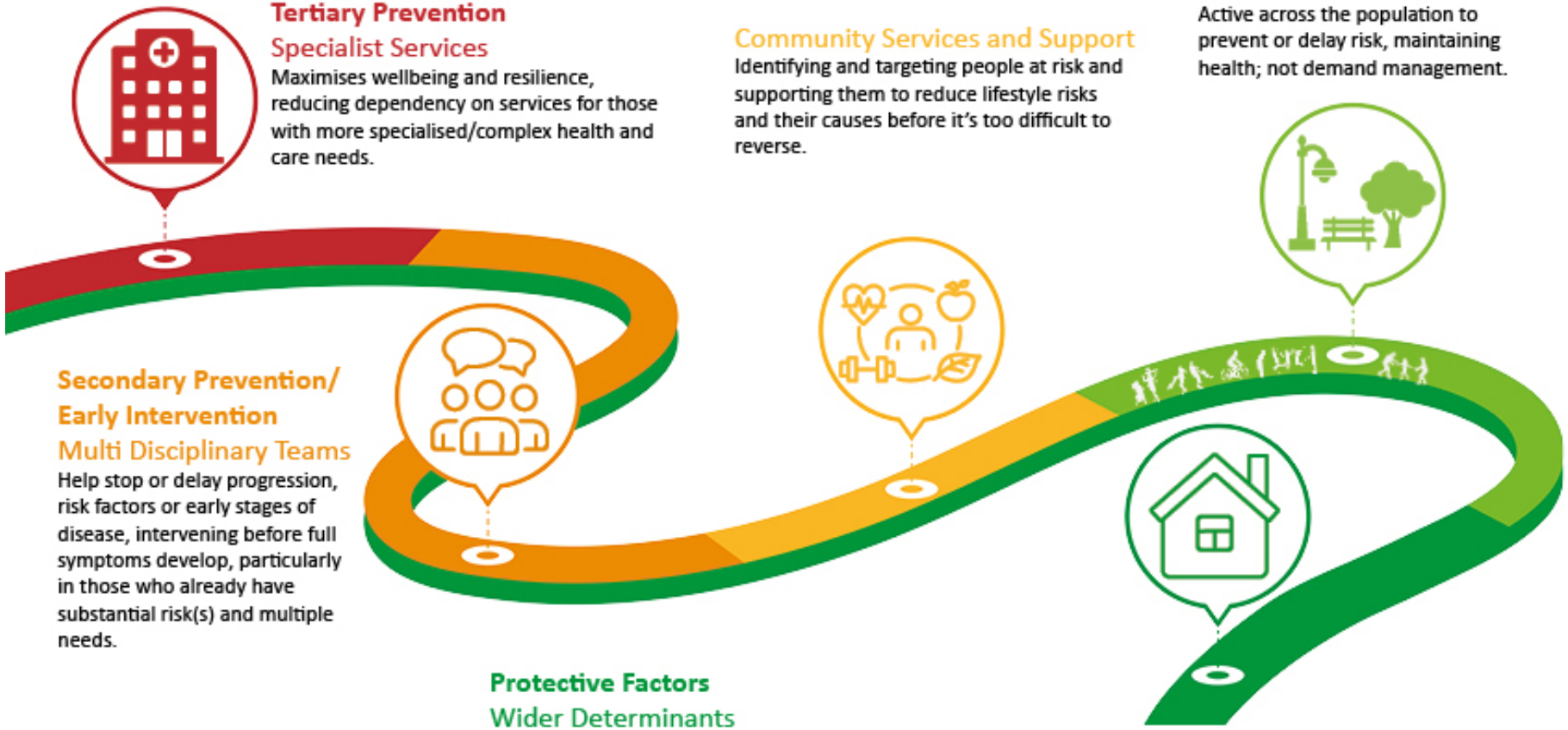
The Prevention Framework builds on the existing place-based offer, creating one brand to put the lives and health of community and people at the heart of everything. This will be done by providing support and sign-posting for access to self-help, expanding targeted support through brief interventions and referrals into appropriate specialised services which ultimately will minimise demand on wider health and local authority services.

Under this Framework all residents will have access to a community that supports them to thrive, including work, physical, green-blue and life-long activities, social networks, information and access to local support. This Framework will enable us to achieve our ICS ambitions of taking a person-centred approach to prevent ill health; empowering individuals to lead healthy lives, giving them greater choice and control where they need it. It is also about identifying and providing effective early support to all age groups and targeting those most in need and those at risk of poor outcomes. It is a shift from a reactive approach to a more holistic, early response or intervention.

The Framework recognises the existing work to also improve the environment in which Shropshire communities live, improving their access to healthy, affordable food and housing, opportunities to be physically active and access to good work and the benefits they are entitled to.

What is prevention and how can services support this?

People being as healthy and well as possible at all stages of life; all services can help with this



Tertiary Prevention

Specialist Services

Maximises wellbeing and resilience, reducing dependency on services for those with more specialised/complex health and care needs.

Primary Intervention - Pre Risk/At Risk

Community Services and Support

Identifying and targeting people at risk and supporting them to reduce lifestyle risks and their causes before it's too difficult to reverse.

Universal Services

Active across the population to prevent or delay risk, maintaining health; not demand management.

Secondary Prevention/ Early Intervention

Multi Disciplinary Teams

Help stop or delay progression, risk factors or early stages of disease, intervening before full symptoms develop, particularly in those who already have substantial risk(s) and multiple needs.

Protective Factors

Wider Determinants

Support at all levels of need and includes access to good housing, education, outdoor spaces, social prescribing and the voluntary and community sector (VCSE).

Our Vision

Focus on developing strong communities where we can reduce inequalities, build the resilience of vulnerable people and families, and concentrate on driving system change so that every area has joined up, efficient local services which are able to identify people and families in need and provide the right support at the right time.

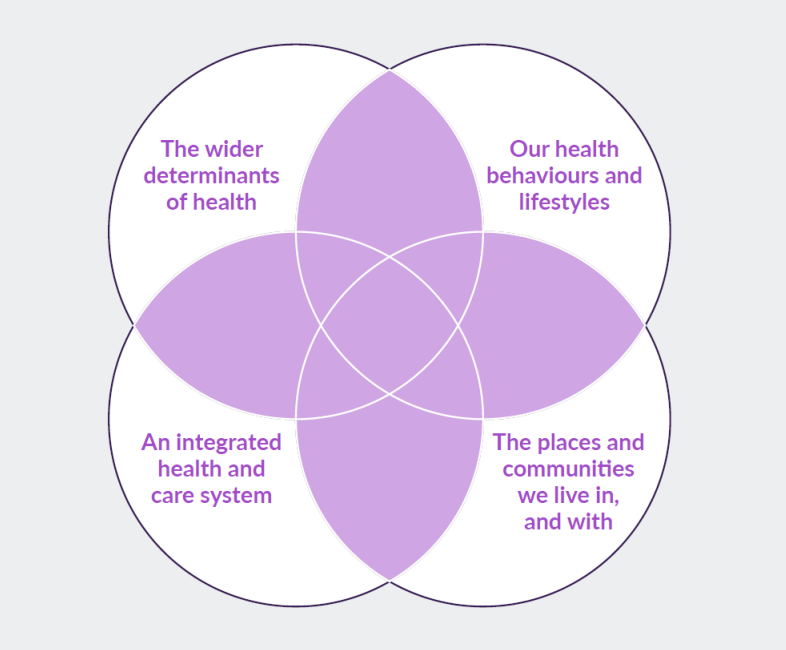
Case Study:
Social Prescribing – tackling anxiety and isolation

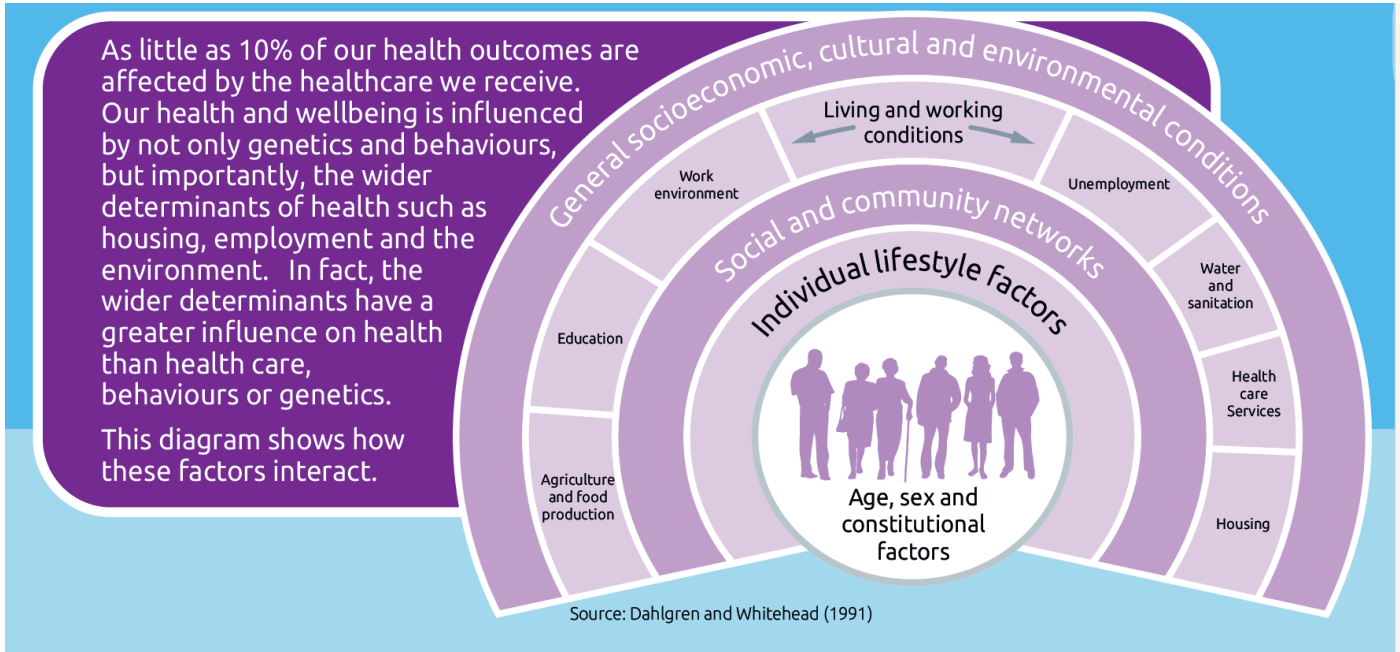
“I get out more now, I meet up with family, I find it hard to manage my life, I do still feel overwhelmed and isolated, but I have found the confidence to be myself, **I go quite often to an outdoor green space now**, I go to look at the spring flowers.

“It’s been good to talk to someone, **someone to listen to me**, I tried to talk to other people and it’s not as beneficial as talking to a professional. You get reasonable conversations with a Social Prescribing Advisor, **honest conversations that have allowed me to think more deeply about my situation and environment**.

“I was sign posted to an **ICT course, I’ve been loaned a tablet to learn**, and there are volunteers and they are encouraging. **I feel motivated**.”

Case for Change - What makes us healthy





"The best way of ensuring a long healthy life is to have the best start in life, a decent education, a warm and loving home and sufficient income to meet our needs. Or to put it more simply - a job, home, family and friends are the things that matter most to our health and wellbeing."

Public Health England

Context– Challenges and Opportunities

Reduced workforce and ability to recruit (lack of trained staff nationally) how are we going to address this gap?

Demand outstripping capacity need to look at different models to achieve outcomes

Increased complexity of caseloads and safeguarding issues (42% school nurse caseload currently is safeguarding)

Reduction of prevention / early intervention historically

Impact of Pandemic and increase in mental health issues for young people and families including access to specialist service for CYP's mental health

Schools left 'Holding the Baby'

Shropshire is a relatively affluent county masking pockets of high deprivation, growing food poverty, rural isolation, and geographic disparities in the health and well-being of children and young people.

It's a mostly rural county and the largest inland county in England with 66% of the population living in villages, hamlets and dispersed dwellings.

Funding across the Shropshire, Telford and Wrekin system is an ongoing challenge seeing significant reductions over time

In Shropshire, children and adults have poorer outcomes for people with mental health issues, than its statistical neighbours. The County has the third lowest NHS investment in the country in mental health services.

There is a system wide agreement that both children and mental health in children and adults, is a system priority.

Case Study:

Rural Art Hub

Joseph lives rurally and has an agreement on the farm where he is a tenant, to use their old diary parlor for community-based art activities.

Joseph was referred to the voluntary and community support team by partners at the Qube so he could receive governance and legal structure advice, funding support and skill-based training.

Joseph's aim was also to eventually become a social prescribing intervention once his new community interest company had formalised and had the necessary health and safety requirements in place.

The Rural Art Hub now enables people, including children and young people from all walks of life to meet and socialise in a creative and welcoming local rural space.

The organisation is soon to be used as a social prescribing intervention to increase people's health and wellbeing and reduce social isolation.

Case for Change

3 main reasons that the **evidence consistently shows Prevention is Better than Cure**:

1. **Improve outcomes** (quality and length of life) - live longer healthier lives increasing time spent in healthy life expectancy
2. It is the most **cost-effective** approach to improving outcomes - 'an ounce of prevention is worth a pound of cure' Prevention works – A review of international studies suggests investment in prevention have a significant long term social return on investment – **Around £14 Social benefit for every £1 across a broad range of areas**
    - Mental Health nationally costs £105bn a year. In Shropshire cost to health and social care for depression or similar common mental illness is an estimated £1,350 per adult per year. This includes treatment, loss of productivity, human costs and impacts on relationships
    - Diabetes costs an estimated £5,500 per person for health and care costs; which increases where people experience complications
    - Alcohol misuse costs £4.4billion nationally a year relating to alcohol related hard and anti-social problems
3. **Manages demand** – on specialist and more expensive services

Intervention	Return on Investment for every £1 invested to the wider health and social care economy
Teenage Pregnancy	£11 in healthcare costs
School Based: Smoking	£15
Parenting Programmes	£8 (over 6 years)
Keeping active: free use of leisure centres	£23 in quality of life, reduce NHS use and wider
Housing investments: warm safe homes	£70 (over 10 years to NHS alone)
Disadvantaged groups in work	£3 (reducing crime, homelessness and care)
Social Support: Befriending	£3.75 (mental health spend)
Motivational Interviewing	£5
Drug Treatment	£2.50
Mental Health Interventions	Between £1,26 and £39
Falls prevention	Between £1.37 to 7.34
Social Prescribing in Shropshire	£2.29
Smoking in Pregnancy	£5

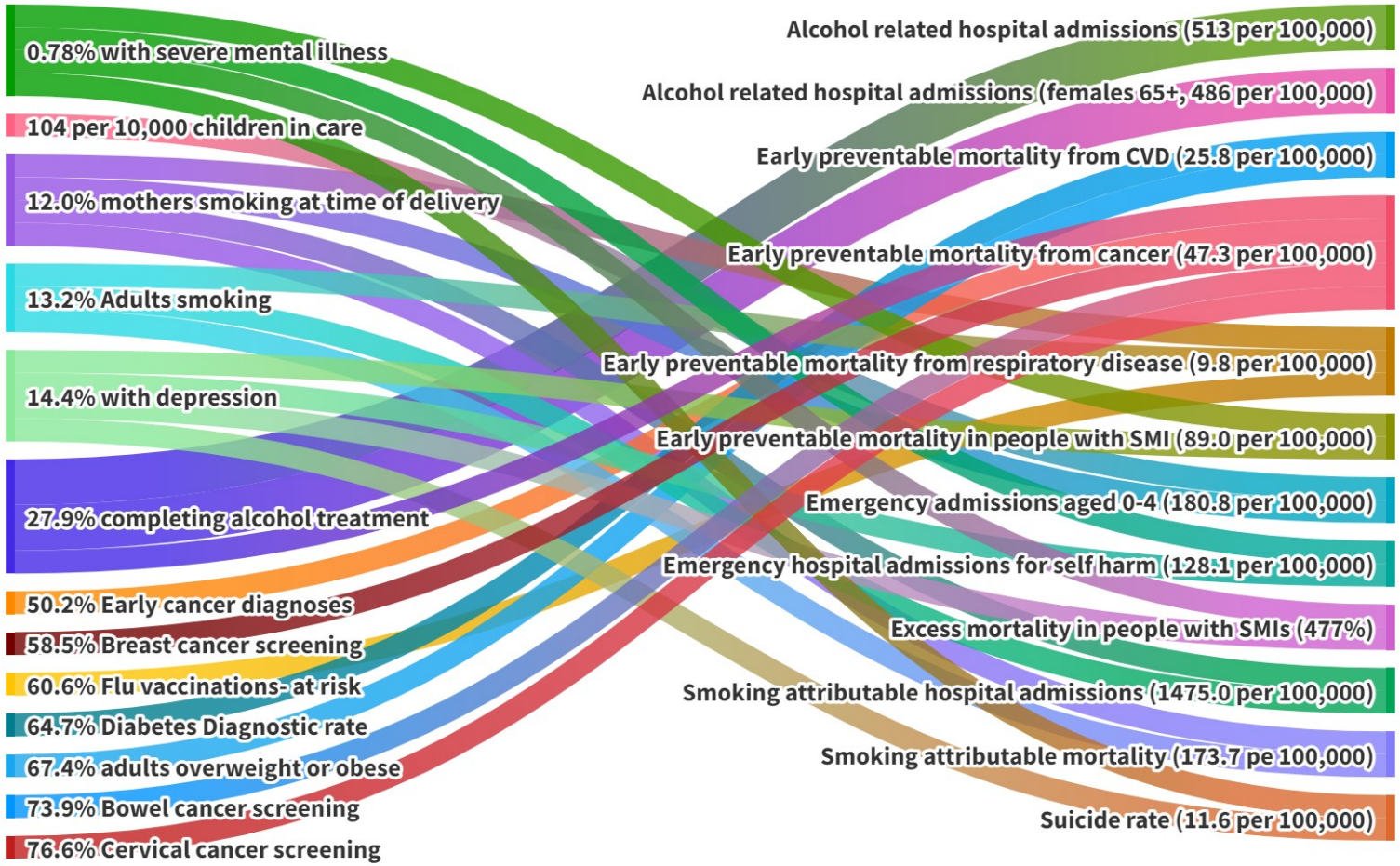
Case for Change

The local picture: Health behaviours, early interventions and preventable deaths and admissions

Compared to national average:
Red = worse
Orange = similar
Green = better

- Early **preventable** mortality (132.4 per 100,000)
- Early preventable mortality from **CVD** (25.8 per 100,000)
- Early preventable mortality from **cancer** (47.3 per 100,000)
- Early preventable mortality from **respiratory** disease (9.8 per 100,000)
- Early preventable mortality from **liver** disease (16.6 per 100,000)
- Early mortality in people with **SMI** (89.0 per 100,000)
- Excess mortality in people with **SMIs** (477%)
- **Suicide** rate (11.6 per 100,000)
- Emergency hospital admissions for **self harm** (128.1 per 100,000)
- Emergency admissions **aged 0-4** (180.8 per 100,000)
- **Alcohol** related hospital admissions (females 65+, 486 per 100,000)
- **Alcohol** related hospital admissions (513 per 100,000)
- **Smoking** attributable mortality (173.7 pe 100,000)
- **Smoking** attributable hospital admissions (1475.0 per 100,000)

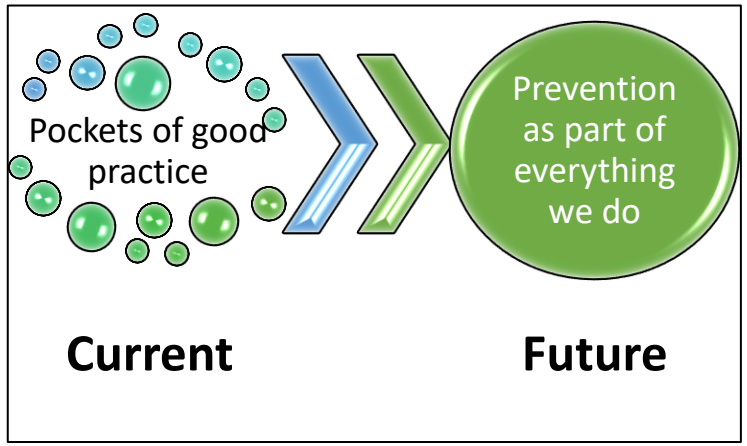
The chart below demonstrates that health behaviours lead to many adverse outcomes and put strain on health and care services.



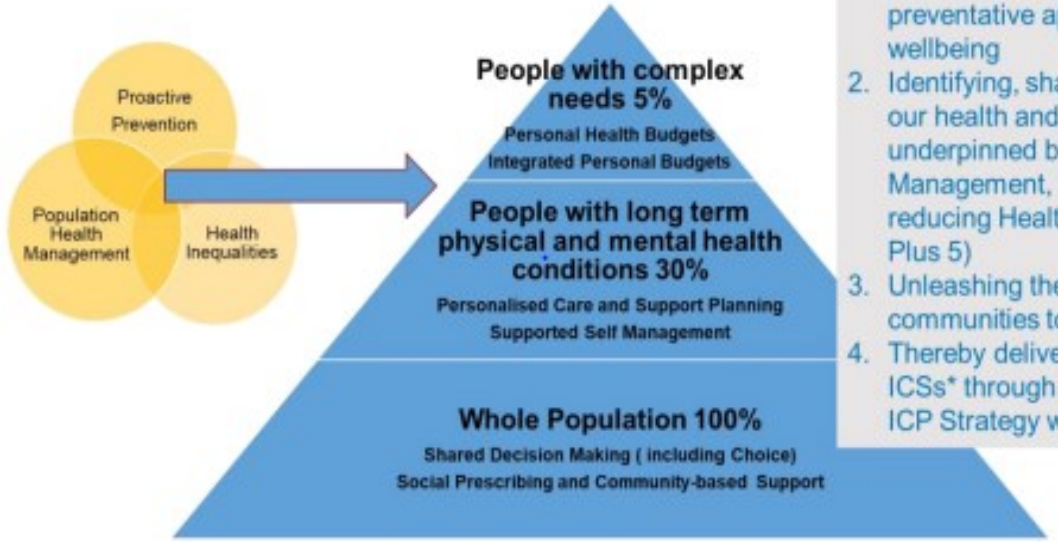
Click here to view the interactive version to view specific relationships.

Source: Flourish

Case for Change - Addressing Inequalities, taking a person-centred approach



We have lots of good work already underway in Shropshire and pockets of good practice/test and learn evidence-based approaches delivering benefits, but we need to resource and deliver universal services at a scale and intensity proportionate to the degree of need.



1. Reframing our relationship with the public – taking a whole person, preventative approach to health and wellbeing
2. Identifying, shaping and delivering our health and care priorities underpinned by Population Health Management, Proactive Prevention & reducing Health Inequalities (Core 20 Plus 5)
3. Unleashing the full potential of our communities to enable this
4. Thereby delivering the 4 aims of ICSs* through co-production of our ICP Strategy with delivery of Place

*Integrated Care Systems exist to achieve 4 aims:

- Improve outcomes in population health and healthcare
- Tackle inequalities in outcomes, experience and access
- Enhance productivity and value for money
- Help the NHS support broader social and economic development

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Case Study:

Leisure and Tourism

The Muddy Boots Club, funded by the Veolia Envirogrant scheme and jointly organised by Market Drayton Library and its Friends group, aims to encourage pre-school children, who are confident walkers, to get out and about in nature, playing, creating and discovering

In addition to the animal encounters, the children have also engaged in several other eco-friendly activities, such as making bird feeders, leaf rubbings, bug spotting and seed planting.

Thanks to the Muddy Boots Club, many children and their parents have discovered new areas of the town, met new people, enhanced their well-being and developed new skills.

Our Approach -

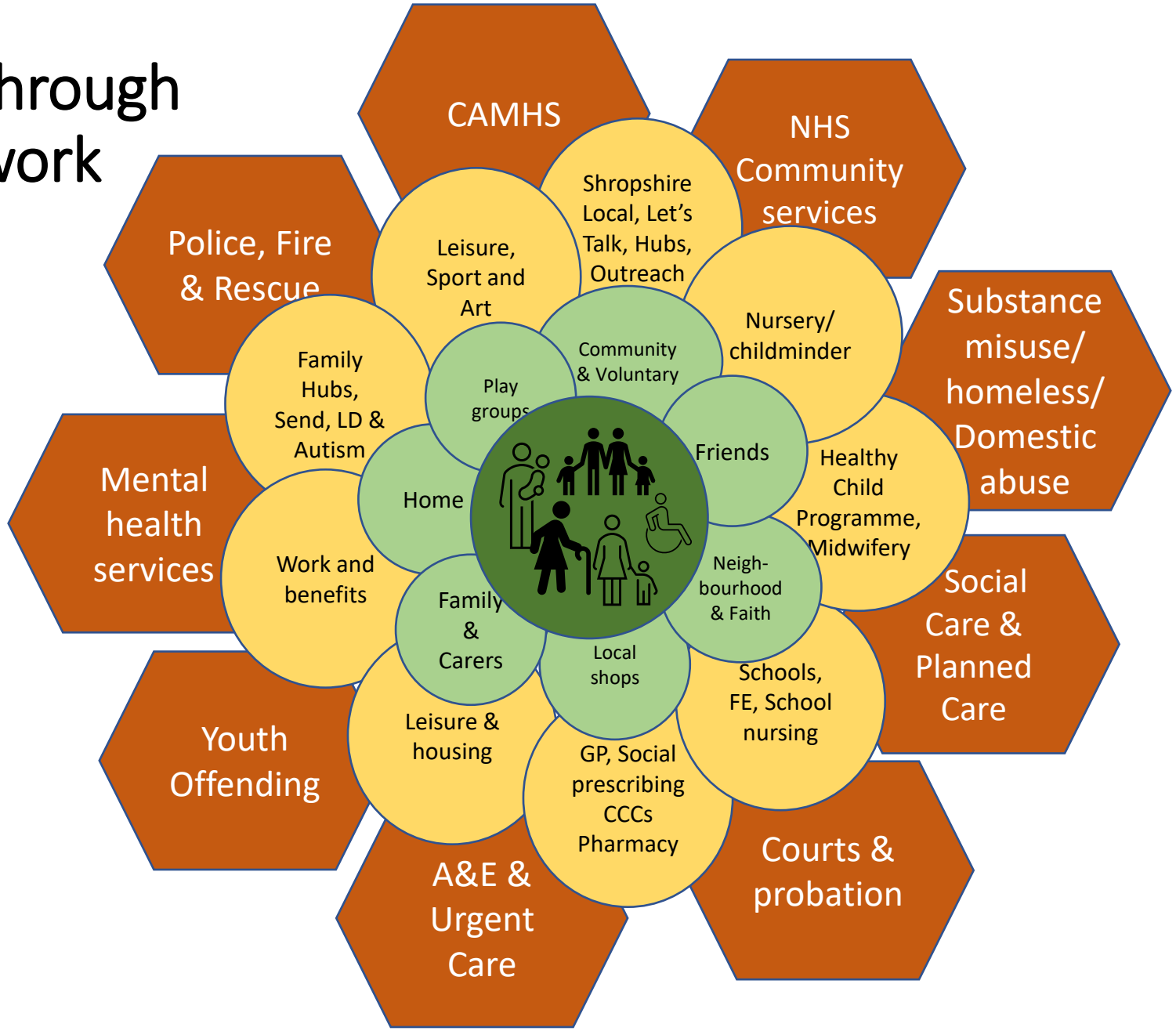
Developed in partnership through integration test and learn work

Person-Centred Care

People and communities are the cornerstone of how we will work.

Our programmes will focus first on supporting people to help themselves, followed by ensuring there is high quality, integrated, easily understood universal services for people to access, where they need it, when they need.

If further intervention is needed our approach will ensure high quality, integrated, easily understood specialist services are available.



Case Study:
Bolster community and VCSE - Age UK Activity Groups

“I love the Women's Walking Football in Shrewsbury. I have met new friends, my mental and physical health have improved greatly with the team camaraderie. The group leader is great and we all have a say in the direction of the group. More team sports for over 55 women please! I know everyone else in the group feels the same - it's good exercise, and competitive and great fun. Thank you for this opportunity.”

“Thanks to Madelaine and Paul our teachers, our line dancing group is amazing. Claire Fishlock is wonderful, she is friendly efficient and brings our club together socially. it is extremely good for those who otherwise would be alone at home. BRILLIANT!”

Our commitments

1. Proactively working with people of all ages, their families, and carers to improve wellbeing (eyes and ears on vulnerable people)
2. Ensuring that we take a person-centred approach, putting people at the centre of what we do
3. Work to develop a more comprehensive community-based prevention offer which includes universal, early help and targeted and specialist system services – One Shropshire
4. Work across service areas, integrating where possible, embracing partnership and collaborative working, creating a culture of working jointly across professions, organisations and teams for the benefit of our communities
5. Ensure evidence-based activity, population health data and other insight data (from services, locality JSNA, local consultations and the community) is used to inform planning and delivery; using data to find those most in need, focussing on inequalities
6. Adopting a test and learn approach, allowing projects time to evolve and deliver outcomes, embedding evaluation in all development programmes from the start

Opportunities - Journey so far best practice

1. Agreed strategic support for a preventative approach
   - Integrated Care Partnership (ICP) Strategy, Health and Wellbeing Board Strategy, Partners Key Corporate Plan e.g. Shropshire Plan, West Mercia Police Prevention Strategy, Fire and Rescue, VCSE
2. Preventive Programmes are in place already across the County just some of the examples are included below:
   - Early Intervention (adults and children's), Let's Talk Local, Housing support, outdoor activity and green Spaces, culture Leisure and Tourism, Best Start in Life, Finding Dave
   - Wellbeing and Independence Partnership, Warm Welcome, Elevate, Enable, Social Prescribing
   - Problem Solving Hubs, Safe and Well Checks
   - Targeted Shropshire Together Programme – Healthy Lives including trauma informed, wellbeing campaign
   - Lifestyle programmes: sexual health, drugs and alcohol, healthy lives team, 0-19 service, health checks
   - Alcohol care teams, tobacco dependency teams, NHS digital weight management, annual health checks for people with learning disabilities, physical health checks for those with SMI, early diagnosis cancer programmes
   - Further development of pathways/integration
   - MSK, falls, Mental Health, CVD, Trauma informed approaches, vaccination, screening
   - Identification of six key projects across the pathway
3. Health in all approach embedded into polices and planning
4. Inequalities Plans

Case Study:

Shropshire Local

Shropshire Local Mobile aims to provide assistance to residents in rural areas where accessing council services and support can be challenging.

Throughout the past year, Shropshire Local has received nearly 17,000 enquiries and provided support to numerous residents on various matters, including concessions, blue badges, council tax, housing and other services. This figure encompasses all enquiries handled at Shropshire Local permanent drop-in points in Shrewsbury and Ludlow, in addition to the mobile service.

During the winter, Shropshire Local Mobile was stationed at libraries across the county, and due to the high footfall experienced in Bridgnorth and Oswestry, the service continued to operate from these libraries.

Shropshire Local Mobile offers a vital link to residents, helping them access advice and support from council services and partner organisations, as well as providing guidance on accessing services online.

Friendly and experienced staff are always available to listen and offer advice, guidance and information to residents.

Case Study:
People Living with Chronic Pain

Community based organisations in Shrewsbury came together to provide physical exercise and social support to people living with chronic pain after a gap in provision was identified by Healthy Living Advisors. Sessions were monthly and combined a mix of discussion and time in a quiet gym for exercise.

The group had a total of 13 regular members from 33 referrals with all reporting improvements in either mental health; reduction in medication and regular attendance to the gym.

All patients increased their satisfaction with life from attending the group; felt happier and had more sense of worth and said anxiety levels had decreased.

"I find the group has been helpful to talk about pain experiences with others."

"I'm done with clinical interventions, we need groups like this for us to get better."

"Without social prescribing and this group, I wouldn't be here now. You have saved my life."

Delivering the Priorities

System-wide priorities 2023 – 2027 Steps to delivery

- Action Plan
- Monitoring Delivery of the Strategy and Plan Outcomes

Priority 1: Access and One Shropshire

Ensuring a well understood front door with access to information and advice, that focusses on self-care.

P = Primary
S = Secondary
T = Tertiary

Activity	Action	Indicator of Progress	P	S	T
Develop a strong community directory that is used by the community and other services	Develop an online digital directory for signposting services so that there is one resource for all information (NHS and VCSE). Easy for public to be signposted and supported by a communications and training programme for staff (not just health and social care staff but fire, police, volunteers etc) at front door (physical and every contact)	Directory available and kept regularly updated			
Promote physical activity and reduce social isolation	Expansion of Healthy Lives	Number of referrals into social prescribing			
	Expansion of Healthy Lives to include specialist services e.g. Swap to Stop/ Stop Smoking	Reduction in number of smokers in targeted areas			
	Improve access to Early Help through awareness raising of SPOC and through	Creation of teams to support level II referrals into COMPAS - speed and response			
	Better identification and support for carers and self-care in order provide better outcomes for carers and may prevent, reduce or delay needs for requiring services. Links with Community Resource Good Neighbour Schemes.	Improved support for carers and reduced uptake of crisis services			
	Communications/ promotional campaigns with frontline health and social care staff to better improve awareness of Make Every Contact Count (MECC)	Joined up campaigns such as Community Resource dementia support, sight loss support, group for physically disabled) up awareness events with VCSE and access to VCSE led support groups Increased referrals into services			
Provide better work opportunities and workplace health	Support workplace health initiatives for example Shropshire Wildlife Trust works with businesses through corporate membership and supported development of grounds for lunch walks and provide volunteering opportunities	Increased referrals into services such as screening programmes and social prescribing, including green social prescribing project			
Provide better built environment and outdoor spaces	Increase use and access to Assistive Technology to support people living independently at home	Number of people living at home independently			
	Improve access to outdoor spaces by progressing against Natural England's Natural Greenspaces standards; using Natural England's Green Infrastructure Framework during planning processes.	Progress against the Natural England Framework and standards and Governments Environment Improvement Plan and commitment the public should be able to access green space or water within a 15-minute walk from their home.			
	Work with housing to enhance housing and health initiatives				

Priority 2: Integration and One Shropshire

Enable communities and the voluntary and community sector to take more of central role in the development and delivery of prevention programmes, ensuring all age groups are at the centre of the implementation of the framework.

P = Primary
S = Secondary
T = Tertiary

Activity	Action	Indicator of Progress	P	S	T
Develop integrated approaches	Continue to roll out integration sites to include e.g. community mental health transformation, better integrated virtual working of agencies and teams around people with SMI and multi-disciplinary team working at PCN level.	Roll out of additional sites			
Maximise place-based approach "One Shropshire"	Use existing pockets of good practice to learn from - develop community/family hubs in line with statutory requirements but as an opportunity more effective co-location and integration	Roll out of family/community hubs to include schemes already in place and avoid duplication e.g. housing and debt advice provided to adults with severe mental illness (SMI) and Enable to support people with common mental health conditions into employment.			
	Development of Neighbourhood teams. Co-production and "teams of teams" approach within PCNs to provide proactive, person-centred care with support from multidisciplinary team of professionals and VCSE.	Number of Neighbour teams established. Use Highley has an example model of PCN / neighbourhood level holistic health and wellbeing integrated services			
	Closer working with social landlords	More people living independently			
Establish network of Health Champions	Support community leaders as health champions; continued programme of young health champions via SYA;	More health champions in each neighbourhood			
Resource community and voluntary health groups to enable the growth of solutions	Stepping Stones expansion	Business case modelling and service expansion			
	Better Care Fund to enhance Wellbeing at Home Advice and Advocacy Service	Numbers accessing advice and advocacy			
Build on local businesses role of social corporate responsibility	Healthy Workplace	More awareness of self-care and services available			
	Utilise the employer supported volunteering policy to link work being developed on social value and volunteering				
	Virtual wards	Less hospital admissions/ better hospital discharges			
	1001 Best Start - Programme of activities across health, care, education, nursery, dental	implementation of the six key action areas as part of integration initiatives in CYP			
	Proactive Prevention	Roll out of similar pilots such as the SWS PCN project with Age UK which identifies high frequency attendees in A&E and those with high hospital admissions to target services and avoid hospital attendance			
	Using prevention framework toolkit identify areas where small businesses can support local communities e.g. through social prescribing	More businesses requesting resource pack/ toolkit			

Priority 3: Person Centred Care

Embed Person Centred Care and approach across all organisations and partners.

P = Primary
S = Secondary
T = Tertiary

Activity	Action	Indicator of Progress	P	S	T
Embed the Prevention Framework, putting early intervention, prevention and person centred approached at the heart of all that we do	Develop and train workforce in order to identify prevention intervention in every contact (MECC) e.g. Shropshire Fire and Rescue Service to review safe and well visits to create opportunity to deliver MECC	Development and training of staff in areas such as parent conflict, Make Every Contact Count (MECC)			
	Develop a Framework Toolkit (resource pack) for all colleagues (professionals, communities, VCSE) to provide case studies and practical examples to embed prevention in everything we do	Pack produced and available to all			
Develop and embed person-centred approach the system	Provide opportunities for shared decision making, strength-based conversations and behaviour change conversations and training	Number of people (workforce and voluntary sector) trained, and number of people referred into social prescribing			
Embed early intervention and trauma informed approach while connecting with people	Embed the trauma informed steering group activity across the system, including improved and co-ordinated offer across schools	Number of trauma informed practitioners across the system			

Priority 4: Communities

Bolster the voluntary and community sector to work with partners across the system to support those in need.

P = Primary
S = Secondary
T = Tertiary

Activity	Action	Indicator of Progress	P	S	T
Embed voluntary sector data and intelligence in the JSNA planning and delivery	Better information sharing and co-design of JSNA. Avoid duplication and harness expertise when setting up schemes across the system/ shared resource to co-ordinate and facilitate best practice	Easier access to client information and insight e.g. North Shropshire PCN project to make mental health practitioners available at foodbanks in Whitchurch, Oswestry and Market Drayton. Opportunity to roll out and target with those seeking help for fuel poverty/affordable warmth			
	Better integrated and shared learning from Falls Prevention programmes. e.g. Community Resources runs falls prevention events including functional fitness MOT . Use JSNA information on need as to where to target similar programmes	Number of people accessing prevention services			
	Core 20 Plus 5 Cancer Screening Programme	Number of people accessing cancer screening services. Better opportunities to work joined up using Cancer Champions?			
	Core 20 Plus 5 CVD Risk	Number of people having blood pressure checks			
	"System-wide Prevention Awareness Campaigns Health Promotion (mental health, drugs, weight, alcohol, sexual health)Neglect-in conjunction with VCSE health awareness events - Targeted to carers, inequalities groups"	Increased self-referrals into services			
	Each place and community will have different demand and needs and the CYP Needs Assessment will help inform what services are needed to support children, young people better.	Better understanding and targeted support			
	As above, the JSNA will help inform and target the support and required need for prevention intervention	Better understanding and targeted support			
Develop the culture and practice across the system to implement new ways of working across adults and children's services, whereby everyone has a responsibility for preventing ill health – physical and mental health	Preconception				
Better support community activity and VCSE infrastructure to unleash power of communities	Working collaboratively across health and care to identify resource	Increased volunteering and community activity			

Monitoring Delivery and Governance

The Prevention Framework brings together the aims and ambitions of the Health and Wellbeing Board and ShIPP to take a person-centred approach to prevent ill health and empower people to lead healthy lives.

Therefore, all activities and aims will be brought together, monitored and measured through both these forums.

Appendices

Glossary

- **Tertiary Prevention 5% of population**

Maximises wellbeing and resilience reducing dependency on services for those with more specialised/complex health and care

- **Secondary Prevention 30% of population**

Prevention in those who already have substantial risk(s). Often multiple needs DELAY and or DIVERT, MANAGE DEMAND. TARGETED EARLY HELP

- **Early Intervention with Risk**

Identifying people at risk and supporting them to tackle the risks before it's too difficult to reverse. PREVENT OR DELAY

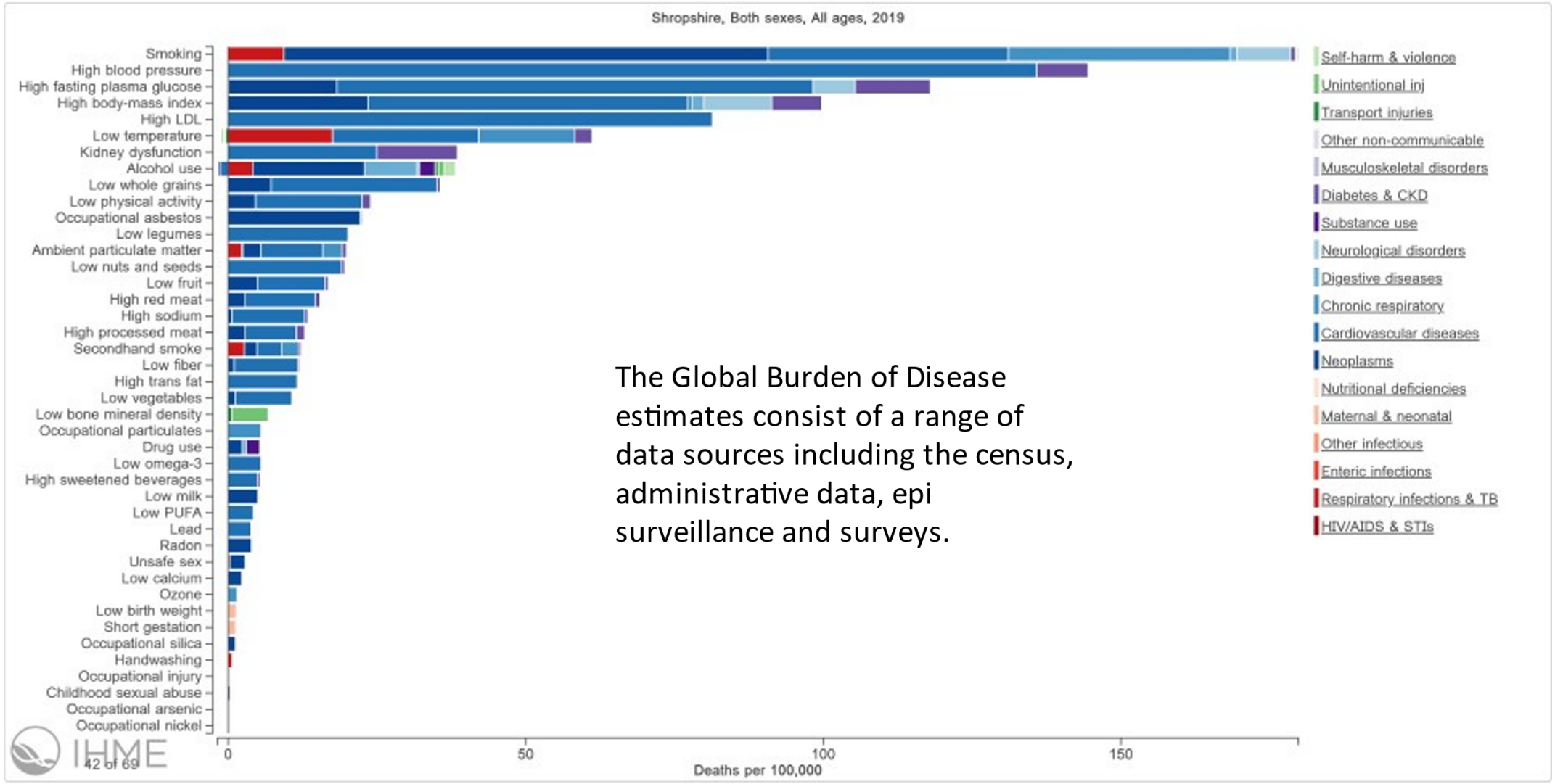
- **Prevention/ Pre-Risk 100% Population**

Some might be at risk or disease reduction at a population level. Maintaining health. Not demand management. PREVENT UNIVERSAL

Evidence base: Scale of the Opportunity

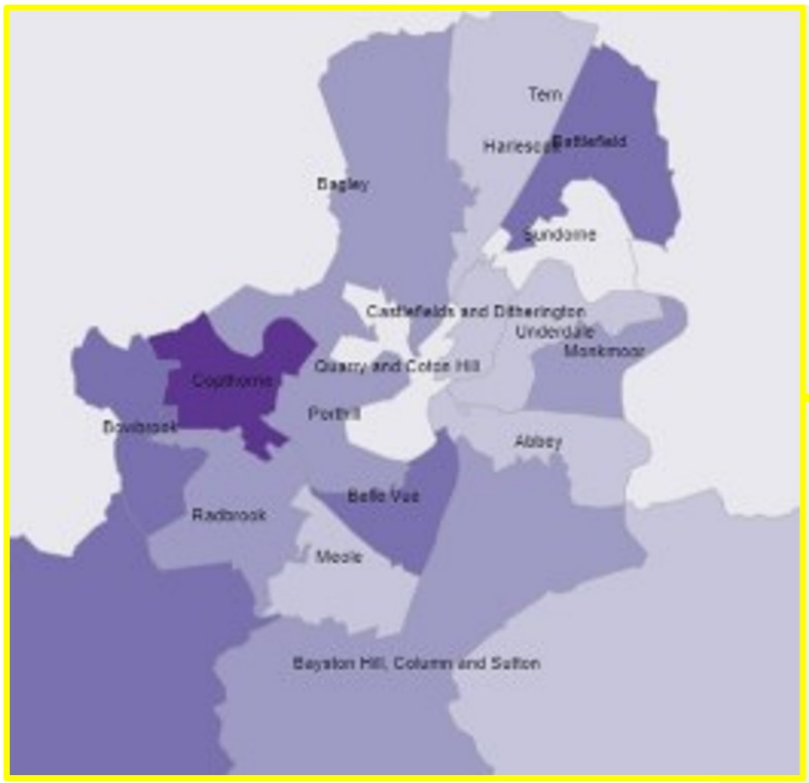
Evidence base: Scale of the Opportunity

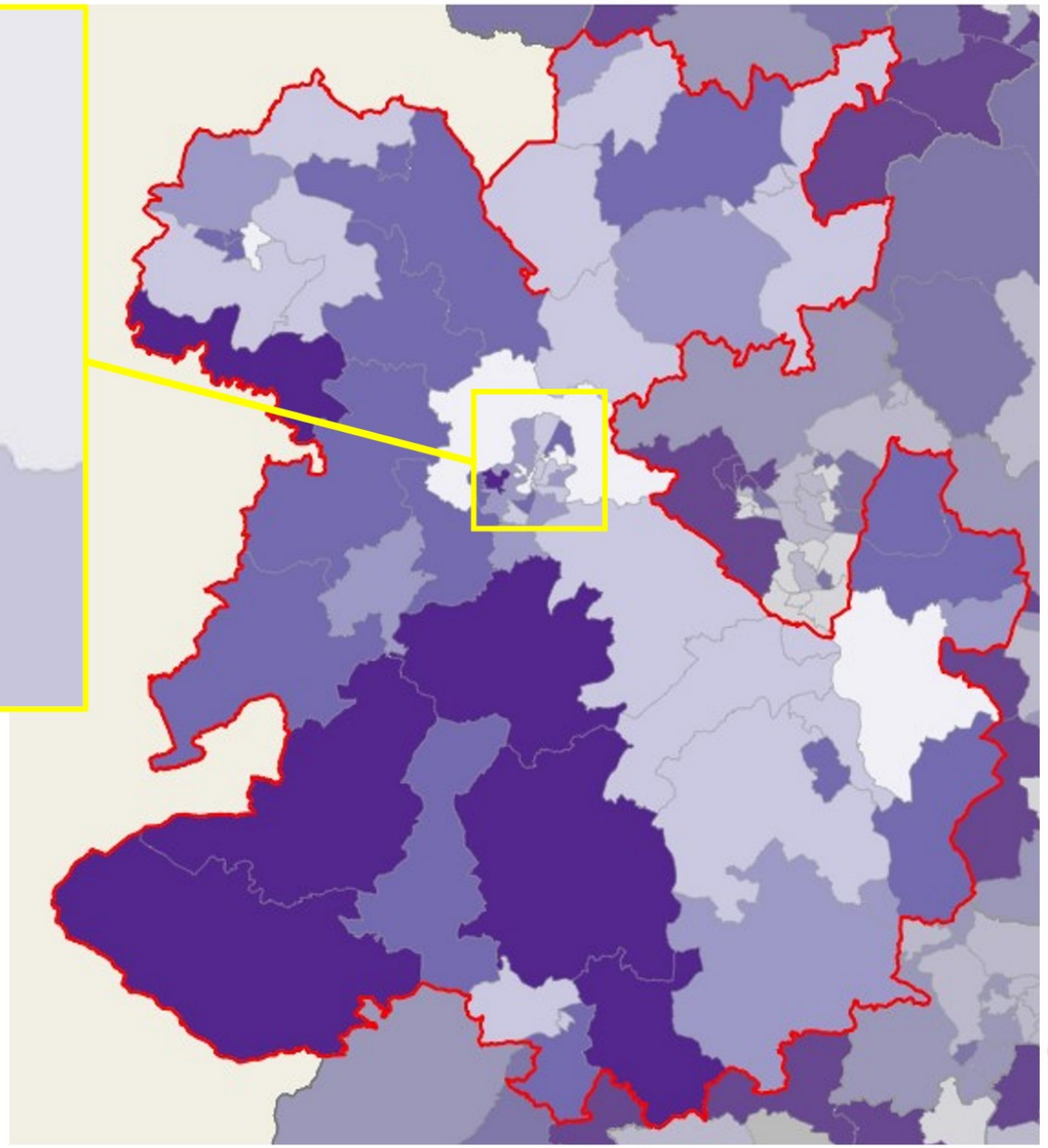
Burden of disease in Shropshire and contributing risk factors



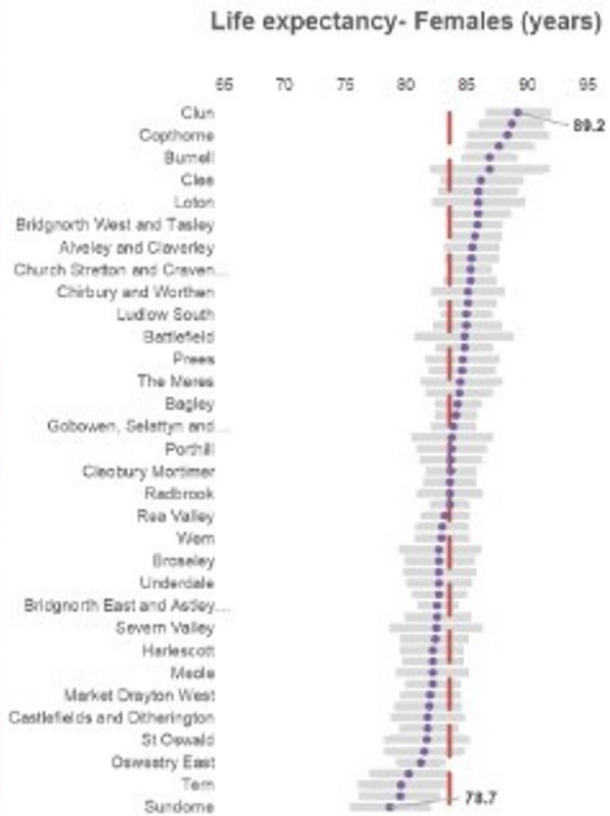
The Global Burden of Disease estimates consist of a range of data sources including the census, administrative data, epi surveillance and surveys.

Life expectancy at birth (Females) - 2016 to 2020 - Shropshire

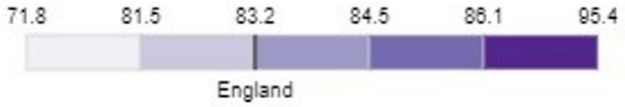




Darker colours = higher life expectancy at birth

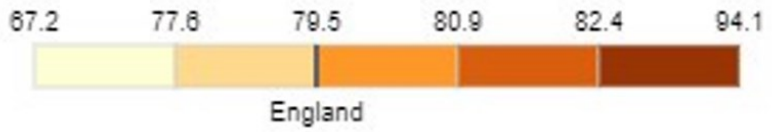


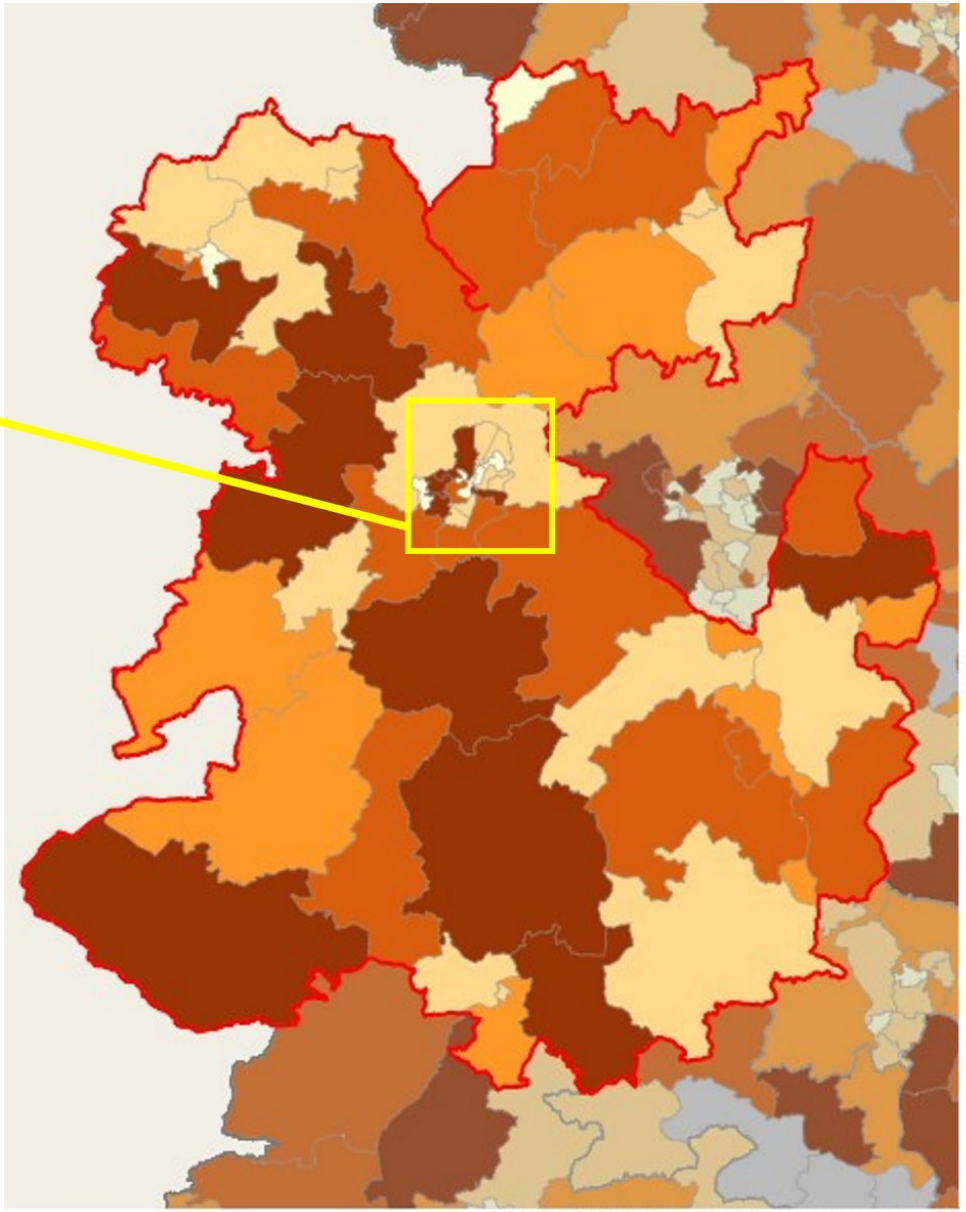
Females living in Copthorne **live 9.7 years longer** than males living in Sundorne, which is ~4 miles apart within the Shrewsbury area.



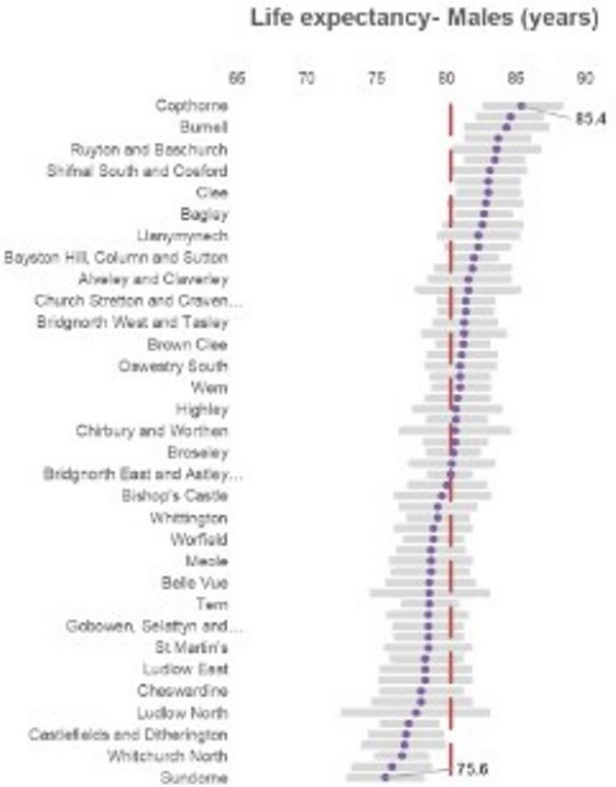
Life expectancy at birth (Males)- 2016 to 2020- Shropshire

Males living in Copthorne **live 9.8 years longer** than males living in Sundorne, which is ~4 miles apart within the Shrewsbury area.





Darker colours = higher life expectancy at birth

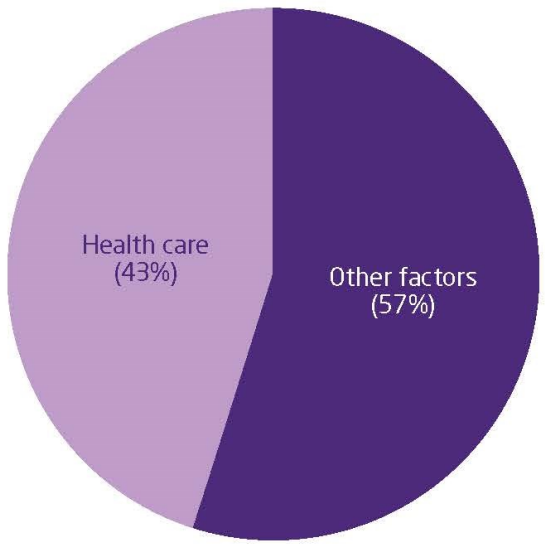


Evidence base: Return on investment

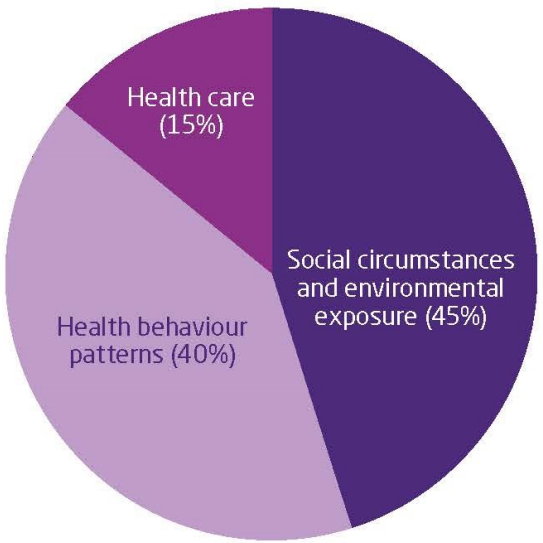
The importance of public health

Our health is determined by our genetics, lifestyle, the health care we receive and our wider economic, physical and social environment. Although estimates vary, the wider environment has the largest impact.

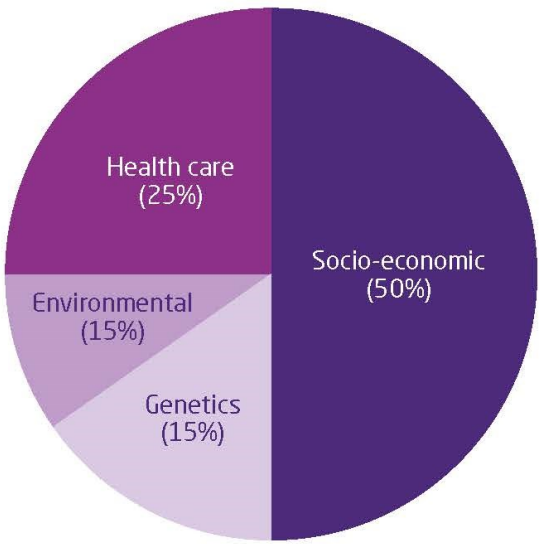
Bunker et al (1995)



McGiniss et al (2002)



Canadian Institute of Advanced Research (2012)



The Kings Fund

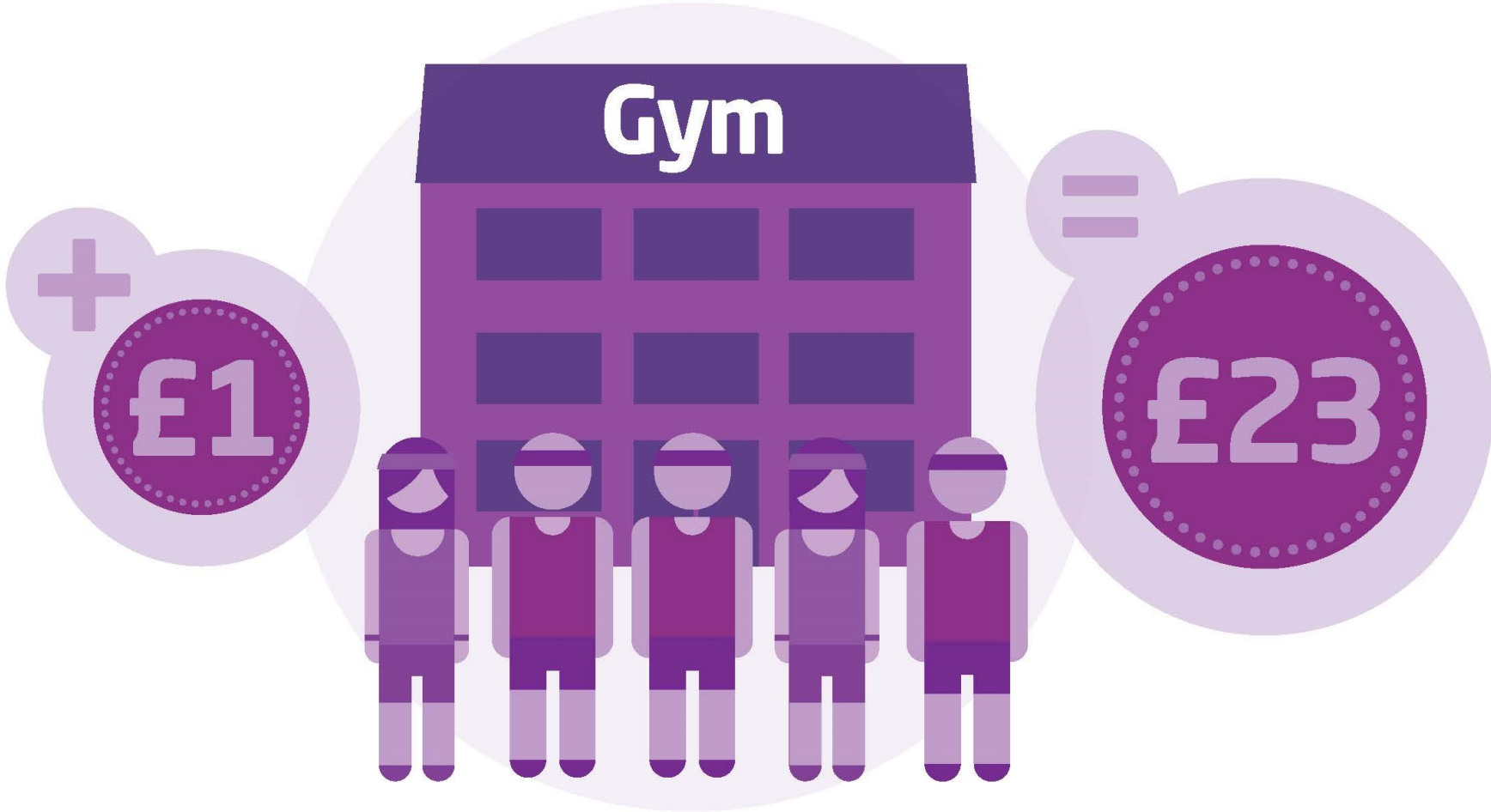
Local Government Association

Return on investment

Housing interventions to keep people warm, safe and free from cold and damp are an efficient use of resources. Every £1 spent on improving homes saves the NHS £70 over 10 years.

The Kings Fund

Local Government Association

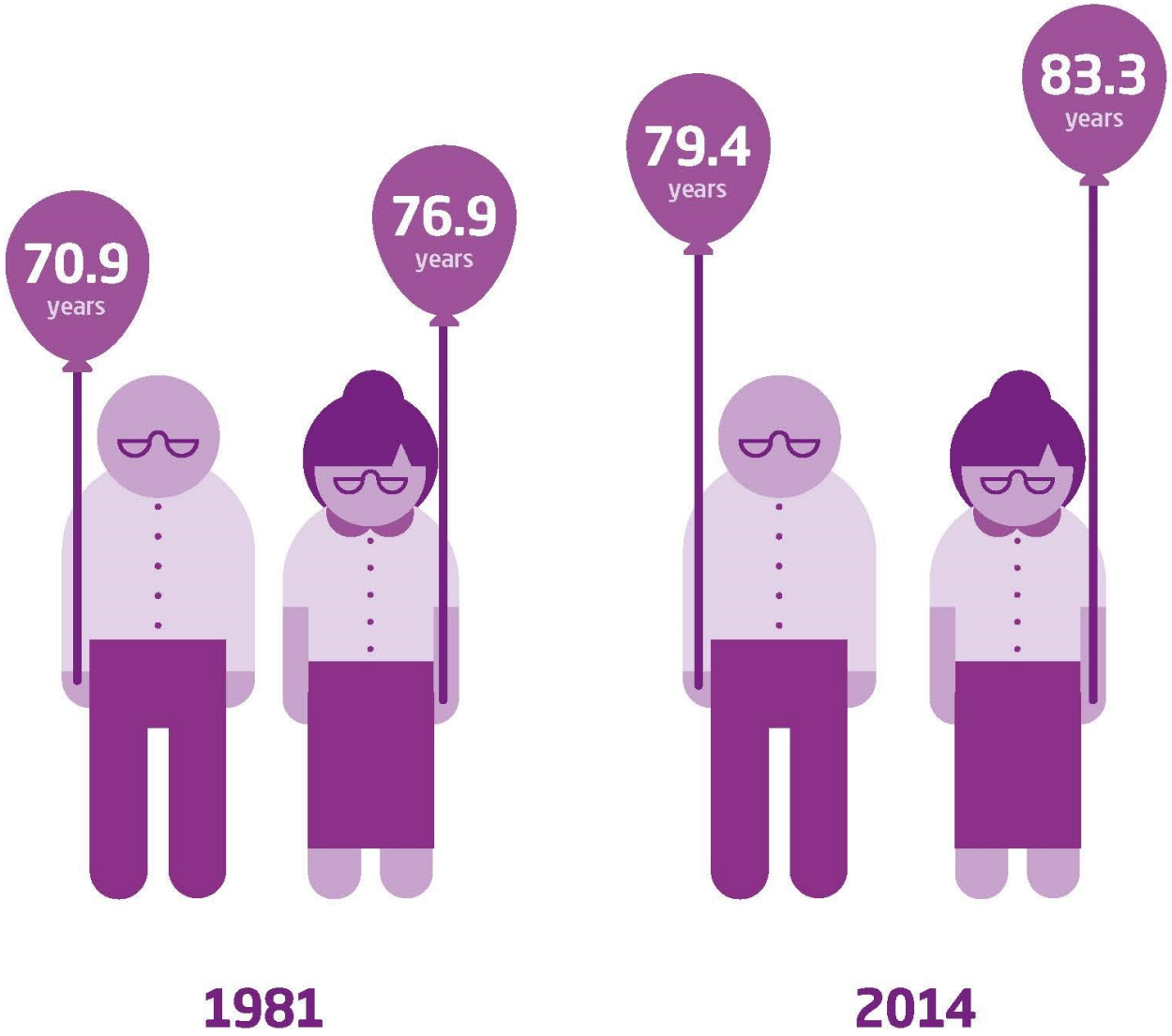


Return on investment

Birmingham's Be Active programme of free use of leisure centres and other initiatives returned an estimated £23 in quality of life, reduced NHS use and other gains for every £1 spent.

The King's Fund

Local Government Association



Life expectancy

The average life expectancy in England has been increasing. In 1981 it was 70.9 years for men and 76.9 years for women. In 2014, it is expected to be 79.4 years for men and 83.3 years for women.

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Healthy life expectancy

People living south and west of London have a far higher healthy life expectancy than people in the north, Midlands and parts of east London. In 2010-12, the healthy life expectancy for women ranged from 52.6 years within Bradford Clinical Commissioning Group to 71.3 years within Guildford and Waverley Clinical Commissioning Group.

The King's Fund

Local Government Association

Spending and costs

The costs of health and care services are not widely known. Some costs can be avoided or reduced through cost-effective public health interventions.

The Kings Fund

Local Government Association

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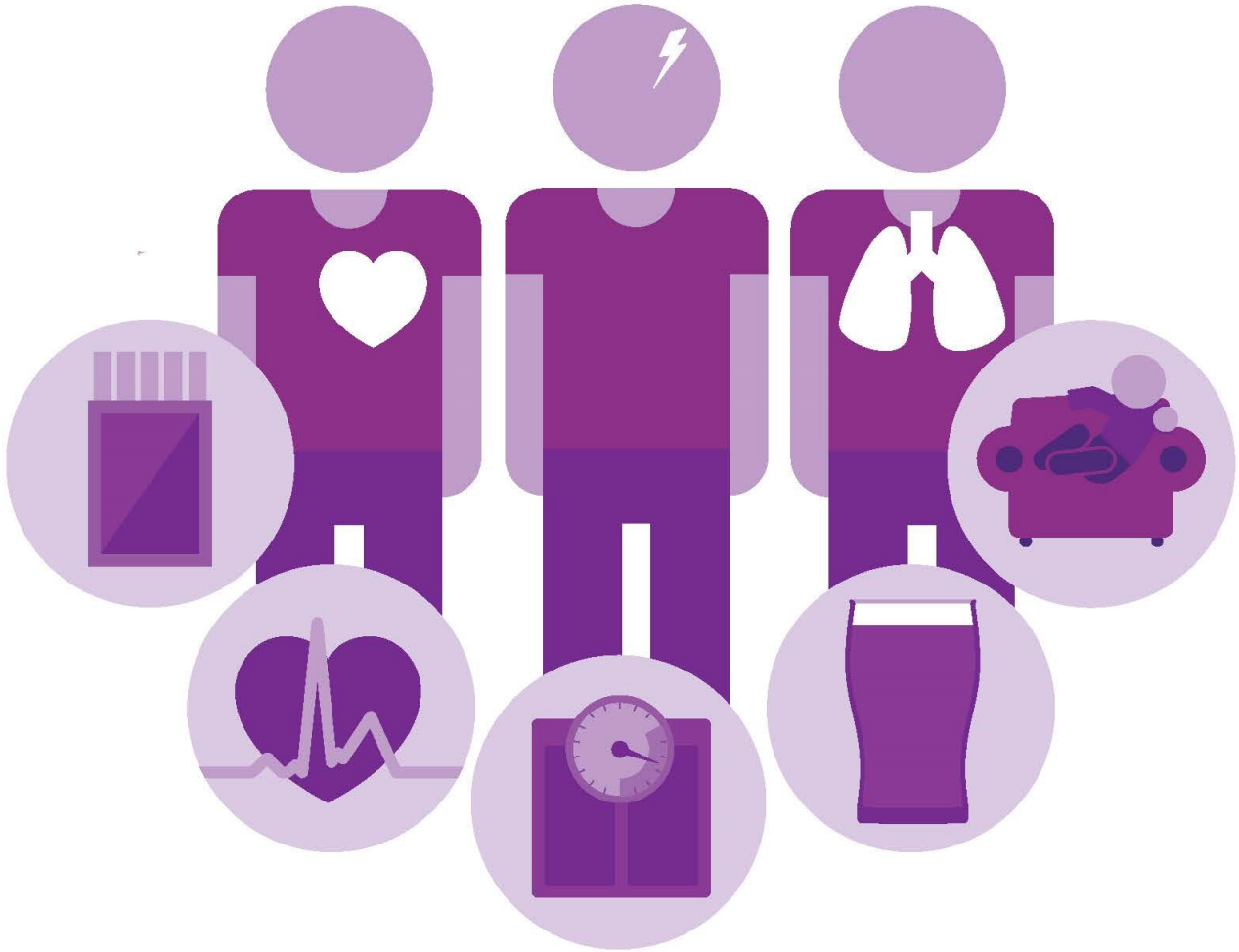

Health and behaviour

Forty per cent of the UK's overall disability-adjusted life years lost are caused by tobacco, high blood pressure, overweight and obesity and low physical activity (2010 figures). This is through their contribution to diseases such as heart disease, stroke and lung cancer.

40% of disability-adjusted life years lost

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