The Annual Report of the Director of Public Health.

Health in Cumbria 2009: Allerdale. Carlisle. Copeland. Eden. Furness. South Lakeland.

Inequalities in health & levelling up. The demographic challenge. Re-orientating health and social care services to be closer to home in Cumbria. A health system based on good intelligence. Building capacity.

Foreword

In this year's report I have concluded that the health of Cumbrians is generally good and improving, but the overall position masks some alarming disparities.

This is my second annual report on the health of the people of Cumbria. Reports such as this have a long history, having begun with the work of the country's first medical officer of health, William Henry Duncan, in 1847. They represent an independent review, which in the days of Local Authority public health departments were presented to the annual general meeting of the borough council in public. Many of these reports were produced over the years by the Cumbrian local Medical Officers of Health.

The purpose of this report is to:

- Contribute to improving the health and well-being of the local population.
- Help to reduce health inequalities.
- Promote action for better health through measuring progress towards targets.
- Assist with the planning and monitoring of local programmes and services that impact on health over time.

In my lecture for the 2008 Annual Public Health Report I outlined five challenges:

- Inequalities in health and levelling up.
- Demographic issues.
- Re-orientating health and social care services to be closer to home in Cumbria.
- A health system based on good intelligence.
- Building capacity.

This year I intend to take a close look at one of these challenges – health inequalities in Cumbria. I will highlight the issues facing us, look at progress so far and give an indication of the actions we still need to take if we are to successfully address the challenges in the future. I will also give a brief summary of progress and further actions needed on the other four challenges.

One of the parables most often told in relation to what has come to be described as the "New Public Health" is that health and social care workers are like lifesavers standing beside a fast flowing river. Every so often a drowning person comes floating down the river; the professionals jump in, pull the person out and resuscitate them. Just as they have finished their task, another drowning person comes floating past. So busy are the 'lifesavers' that they have no time to walk up the river bank to see who or what is pushing everybody in.

This report sets out some concrete proposals for how the health service and other public sector agencies can walk upstream and work with people to help prevent them from jumping or falling in to that fast flowing river.

Dr John R Ashton CBE

Director of Public Health and County Medical Officer, Cumbria

Contribute to improving the health and wellbeing of local populations. Help to reduce health inequalities. **Promote action for better health through measuring progress towards targets.** Assist with the planning and monitoring of local programmes and services that impact on health over time.

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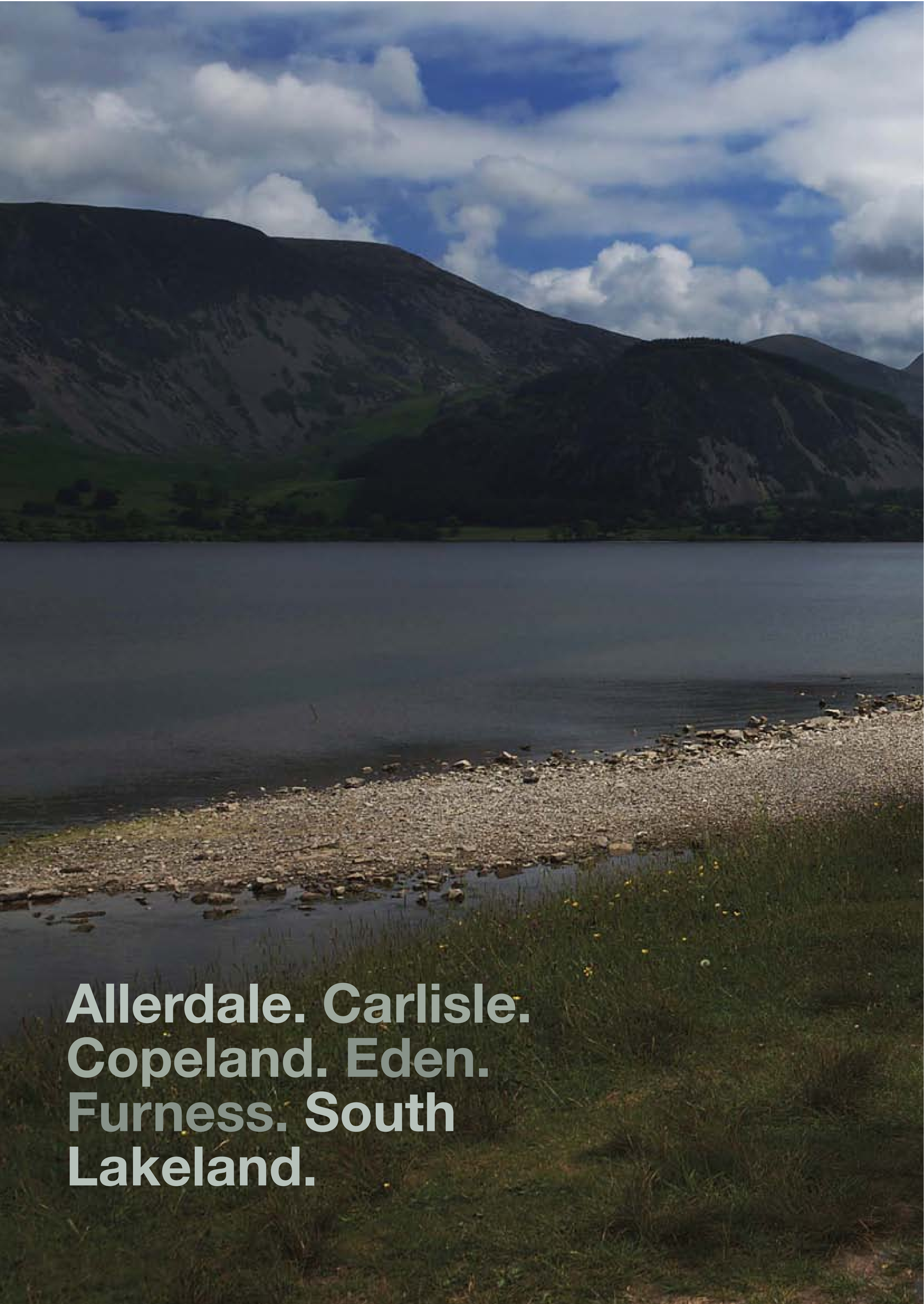
Allerdale. Carlisle.
Copeland. Eden.
Furness. South
Lakeland.

Cumbria at a glance

➔ Cumbria is England's second largest county, representing 48% of the land mass in the North West, with an estimated population of 496,900.

➔ 51% of the total population in Cumbria live in rural communities, compared with 19% in England.

➔ Cumbria has 24 specific communities (super output areas) that are in the 10% most deprived in England and Wales, of which seven are in the worst 3%. This means that approximately 16% of the Cumbrian population lives in areas which are officially rated as among the most deprived in the country.

➔ There were 5,518 deaths and 4,998 live births in 2007.

➔ In 2008, the average house price in Cumbria was £133,598, compared to the national average of £158,946.

➔ In 2008, the average household income in Cumbria was £30,637, compared to the national average of £34,884.

➔ There are approximately 15,000 children under 16 years old (16% of the population), living in income deprived households. This is lower than the national average of 21%.

➔ 319 people were killed or seriously injured in road traffic accidents in Cumbria during 2007.

➔ In November 2008, the rate of unemployment in Cumbria was 2.0% (5,902 claimants) compared to the national rate of 2.8%. The claimant count rose by 503 between October and November 2008.

➔ Around 10% of 4/5 year olds and 20% of 10/11 year olds in Cumbria were classed as being obese in 2007/08.

➔ There were 1,462 deaths from all causes of cancer in 2007. This gives a rate of 173 deaths per 100,000 people, compared to a national average of 174 deaths.

➔ The mortality rate from suicide and injury of undetermined intent was 11.5 deaths per 100,000 population. This was significantly higher than the rate for England at 7.5 deaths.

➔ In 2007/08 the alcohol-harm related hospital admission rate was 1702.1 per 100,000 population, which was higher than the rate for England at 1400.4. It is estimated that 20% of the Cumbrian population over the age of 16 engage in hazardous drinking levels.

➔ Almost every day in Cumbria, one teenage schoolgirl becomes pregnant. The current conception rate of 40 per 1,000 girls under 18 years of age is below the national figure of 42 girls per 1,000.

➔ The life expectancy at birth in Cumbria is 78.4 years, slightly higher than the figure for England of 78.3 years. However, there are major differences between areas with, for example, a 20 year gap between some communities.

➔ There were 18,753 patients included on the GP diabetes register in 2007, accounting for 3.7% of the Cumbria population compared to an average for England of 3.6%.

➔ In 2007 there were 22 deaths under one year old in Cumbria, an infant mortality rate of 4.4 deaths per 1,000 births compared to a national average of 4.8 deaths.

➔ In 2007-08 there were just under 3,000 people registered with a GP with a diagnosis of dementia. It is projected that by 2025 this figure will have more than doubled

ROTTINGTON ROAD
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INGAM
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Section 1:

Introduction

In this section I provide an introduction to the Annual Report, setting out the historical perspective of the role of the director of public health in England and in Cumbria.

Public Health in Cumbria has a long and honourable tradition, with the appointment of local medical officers of health going back to 1879, when John Ward MD was appointed for Westmorland. Our modern-day Directors of Public Health all pay a historic debt to the drive and overwhelming commitment to social reform demonstrated by these early health pioneers.

The Reverend Dr Peter Tiplady, now retired from his post as North Cumbria's Director of Public Health, also recognised the contribution of visionaries like Dr John Heysham, who was the first to develop the "Carlisle Life Table". The Life Table, which was an innovative forerunner to today's area profiles, measured population numbers, longevity by demographic, infection trends, risk factors and mortality levels.

The locally based public health system, rooted in local government, enabled the medical officer of health to contribute to policy and action on local determinants of health through council committees. It was a formidable influence for health protection and improvement.

Many today forget that when the health service was set up, it had three parts to it: firstly the hospital; secondly the general practitioner and related community-based medical services (dentists, pharmacists and opticians); and thirdly the local authority public health department. These departments employed environmental health officers, health visitors, community nurses, social workers and maternal and child health clinics. They also had responsibilities for matters such as food and water hygiene and slaughterhouses.

The public health catastrophes of the 1800s, characterised by cholera and typhoid epidemics, were eradicated partly with the advent of better health services but more importantly as a result of smaller family size, improved housing and environmental conditions and better nutrition.

Today we face different but perhaps no lesser challenges, particularly given the modern western lifestyles: too much fatty food, alcohol and smoking and too little exercise. This lifestyle will compound the added challenges we face in Cumbria: significant health inequalities within and between our communities; an ageing population and declining numbers of children and young people; and the need to deliver world class, modern health and social care for an extremely sparse and dispersed set of communities.

As things turn full circle, we are once again seeing the integration of NHS public health workers with local authority professionals. This is essential for supporting health and social care workers in all organisations to effect real and lasting improvements.

Section 2:

Health Inequalities

In this section I give my definition of health inequalities, show the challenges facing the county in terms of inequalities in health and the wider determinants of health, such as education and housing. I also identify some of the priorities for improvement, some examples of positive action and the issues to be addressed in the future.

The lottery of life in Cumbria

The Losers	The Winners
1 in 4 babies are born into deprivation.	1 in 10 babies are born into affluence.
1 in 5 children will grow up in deprivation.	1 in 10 children will grow up in affluence.
One fifth of their adult life will be unhealthy.	One twentieth of their adult life will be unhealthy.
None will see their 75th birthday.	All will exceed their 75th birthday.

Clearly life isn't fair in Cumbria. This is dramatically illustrated by following the fortunes of 400 babies born in Cumbria: 200 from the least deprived part of the county, 200 from the most deprived. If nothing changes, this is what will happen to them:

	Of the 400 people	Out of the least deprived 200 people	Out of the most deprived 200 people
Health	Claim incapacity benefit	8	44
	Smoke	29	70
	Binge drink	33	51
	Consume 5 portions of fruit & vegetables a day	67	39
	Have a limiting long term illness	30	56
	Class their general health as not good	12	30
	Are permanently sick or disabled	7	32
Education	Get at least 5 GCSEs A to C	151	63
	Will not stay in education	114	169
Home	Are part of a lone parent family	6	35
	Have no access to a car or van	21	112
	Go home to rented accommodation	28	110
Work	Work full-time	82	50
	Claim a key benefit	16	84
	Become a professional or manager	14	6
Experience of crime in the neighbourhood	Burglary	1 every 2 years	2 per year
	Drug offences in the local area	1 every 2 years	3 per year
	Crime	6 per year	54 per year
	Anti social behaviour	5 per year	60 per year
And finally	Have a life expectancy of	82 years	72.6 year

Introduction to health inequalities

Of all the information in my first annual report, in March 2008, the most alarming by far was the gap in life expectancy of up to 20 years between different parts of the county, for example between Greystoke near Penrith and Moss Bay in Workington. It is staggering that, on face value, some people in Cumbria are living up to 20 years longer just because of where they live.

This is just one of the many examples of health inequalities in Cumbria. But what does the term 'health inequalities' mean? The World Health Organisation (2008) says health inequalities are:

> **"differences in health status or in the distribution of health determinants between different population groups"**

This, for example, could include differences in mobility between the elderly and younger populations, or differences in mortality rates between people from differing social classes.

A more detailed definition, by the Association of Public Health Observatories and Health Development Agency (2003), makes reference to the social variations that are known to affect health and states that health inequalities are:

> **"differences between sections of the population which occur as a consequence of differences in social and educational opportunities, financial resources, housing conditions, nutrition, work patterns and conditions and unequal access to health services"**

It is well known that people who come from higher socio-economic groups, who tend to have more wealth and a better education, generally have better health and have a longer life expectancy. In contrast, people from the more disadvantaged areas tend to have the worst health, a poorer quality of life and experience an earlier death. In essence, health inequalities can prevent people from achieving their full potential in life.

Health inequalities stem from differences in people's early life experience, their education and occupational status, exposure to different lifestyles and the environmental risks and diseases to which their life course influences them. This helps to explain the differences between Greystoke and Workington.

Narrowing the health inequalities gap is difficult. The gap nationally remains large and in some areas is widening. The reasons for this are complex, deep rooted, and often cross the generations. Tackling inequalities involves action from a number of different organisations and sectors. Essentially, however, action is required if we are to create a fairer and more just society and to give all people the opportunity for a long and healthy life.

Section 2:

A national view of health inequalities

In 2003, the government set out a programme of action to tackle inequalities in health across the country (Tackling Health Inequalities, Department of Health). The report committed the government as a whole to achieve the following public service agreement (PSA) target by 2010:

- To reduce inequalities in health outcomes by 10% as measured by infant mortality and life expectancy at birth.

The aim of this target is to close the health gap by reducing the relative difference between disadvantaged areas and the rest of the country in two particular dimensions:

- Starting with children under one year, by 2010 to reduce by at least 10% the gap in mortality between the routine and manual group and the populations as a whole.
- Starting with local authorities, by 2010 to reduce by at least 10% the gap between the one fifth of areas with the worst health and deprivation indicators and those of the population as a whole.

The 'Tacking Health Inequalities 2007 Status Report' outlines the progress that has been made in relation to the national PSA target above. It shows that the latest figures for 2004-06 indicate that the relative gap in life expectancy between England as a whole and the one fifth of areas with the worst health and deprivation indicators was wider than at the baseline (1995–97) for both males and females.

The data shows a slight narrowing of the infant mortality gap between the routine and manual socioeconomic group and the population as a whole. The infant mortality rate in 2004-06 (for all babies whose father's occupation was stated) was 4.8 deaths per 1,000 live births. The rate for those in the routine and manual group was 5.6 deaths per 1,000 live births.

The health gap in Cumbria

So how does Cumbria stand against these national measures? Nationally, Carlisle and Barrow have been designated by the Department of Health as 'spearhead' areas, which are regarded as being in the most deprived 20% of the English population. The main target is to narrow the gap between these spearhead areas and England as a whole by 10% by 2010.

The good news is that, in the most recent data released by the Department of Health (Tackling Health Inequalities: 2005-07 Policy and Data Update for the 2010 National Target), Carlisle was the only spearhead authority in the North West which is on track to achieve the life expectancy target for both men and women; Barrow is on track to achieve the target for men but not for women.

Regardless of where you live, in time you will die. This is certain. The age at which you die is of great significance. Premature mortality, that is death that occurs before reaching your 75th birthday, is a good measure of health inequality.

Figure 1 shows the premature death rate by lower super output area and grades them using a traffic light system, where red indicates that deaths are significantly higher in these areas. Green shows that deaths are significantly lower whilst yellow indicates no significance.

This demonstrates a similar picture to the deprivation map, where the bulk of the problem areas are in Barrow-in-Furness, Carlisle and along the West coast.

Figure 1: Premature Mortality: All Causes

Premature mortality, persons 2002 to 2006
by lower super output area

- Significantly higher (51 areas)
- No significance (221 areas)
- Significantly lower (50 areas)

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THWAITES
Smooth
BEER
POCKETS SNOOKER

Section 2:

One of my concerns with the approach taken by Government is that it centres on closing the gap by a small percentage. This can be achieved as a result of reductions in the levels of the best as well as improvements in the worst areas. A more tangible method of expressing how we can address these differences is an approach called "levelling up", in which numbers indicate how many more (or less) cases would make the difference in health levels for defined groups of the population.

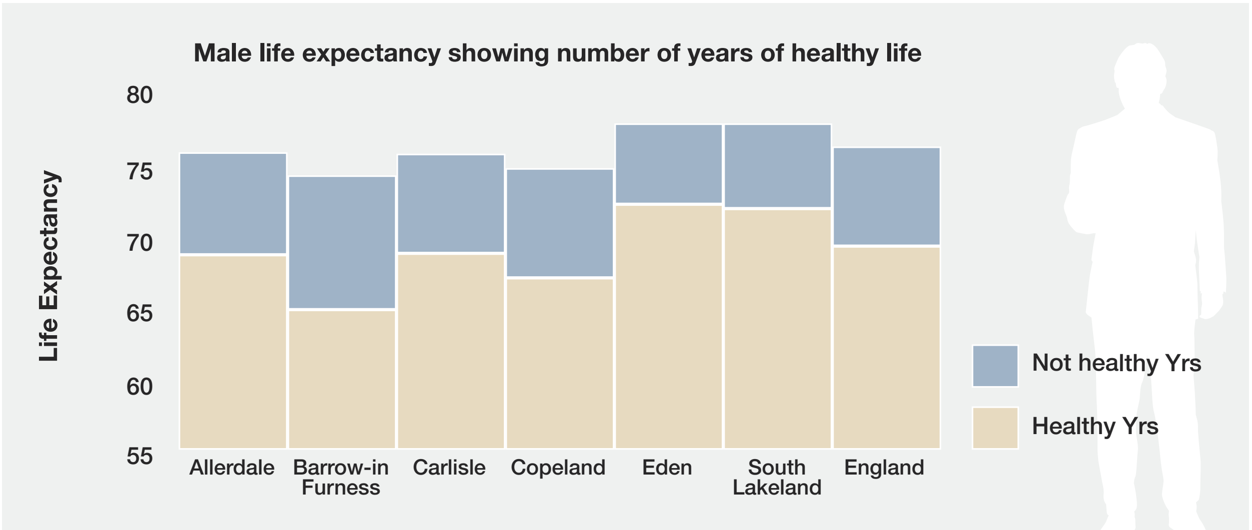
For example, within Cumbria, if the best mortality rate in South Lakeland (534 per 100,000 populations) was applied to each district, we would expect to reduce the number of deaths by 2179 over a three year period or 726 each year (2004 to 2006). The data is shown in more detail in the table below.

Area	Best case	
	Estimated all cause mortality over three years	Decrease from current numbers
Allerdale	2686	576
Barrow-in-Furness	1862	505
Carlisle	2750	604
Copeland	1774	441
Eden	1549	56
South Lakeland	3619	0
Cumbria	14243	2179

Source = NCOD (2007)

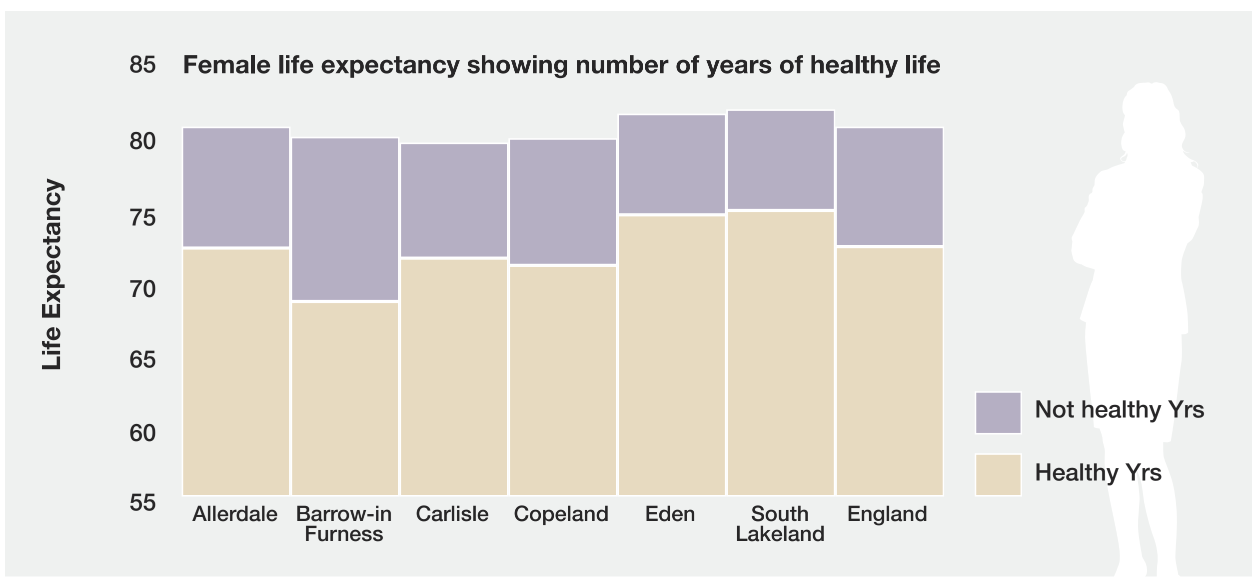
These variations across the county are evidenced not only in how long people live but also how many years are spent in good health and in poor health. Figures based on the last census show a man living in Barrow-in-Furness has an average life expectancy of 74 years. Of these, he can expect to have 64.7 healthy years, with the remaining 9.3 years (13 percent) of his life deemed unhealthy. His opposite number living in Eden can expect to live to 77.6 years with only 5.5 years (seven percent) unhealthy.

Figure 2: Male life expectancy



Women live longer than men in Cumbria. The average life expectancy for a woman living in Barrow-in-Furness is 79.9 years, and she can expect 68.5 years of healthy life, with her remaining 11.4 years (14 percent) as unhealthy. Just across the council boundary in South Lakeland, female life expectancy is 81.8 years with 74.8 healthy years, the remaining 7 years (nine percent) unhealthy.

Figure 3: Female life expectancy



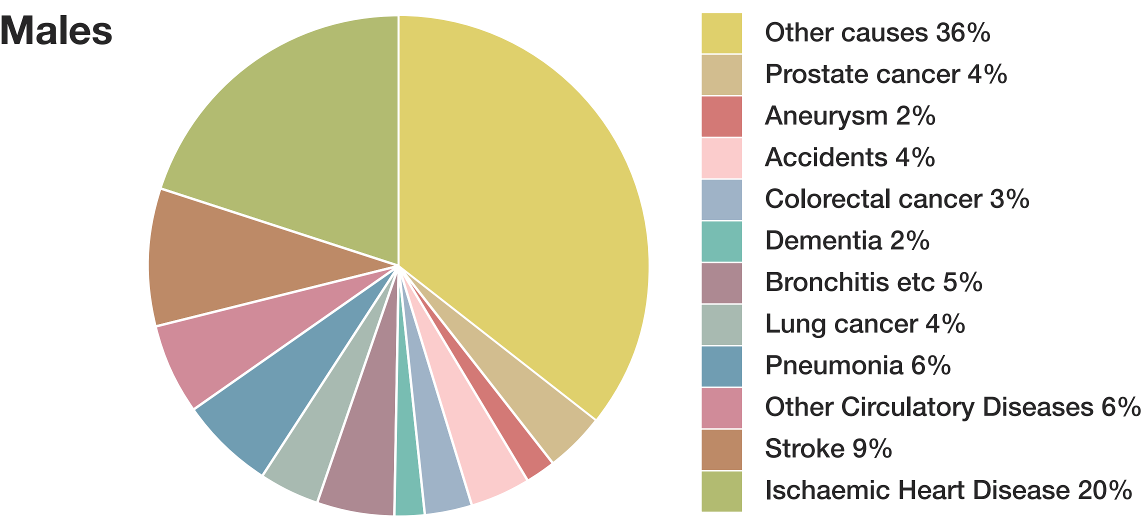
Section 2:

The biggest contributors to health inequalities

The biggest killers in Cumbria are shown in figure 4 below. The graph shows that cancer (including lung, breast, colorectal and prostrate cancer) and circulatory disease (including stroke and coronary heart disease) are the main causes of death in the county.

Analysis included in the Cumbria Strategic Plan shows that premature mortality rates in Cumbria are above the national average for cancer (especially lung cancer) and circulatory diseases (especially coronary heart disease). The analysis also shows that the widest gaps in outcomes in Cumbria are also wide within these two areas.

Figure 4: Major causes of death in Cumbria - 2007. Persons, all ages.



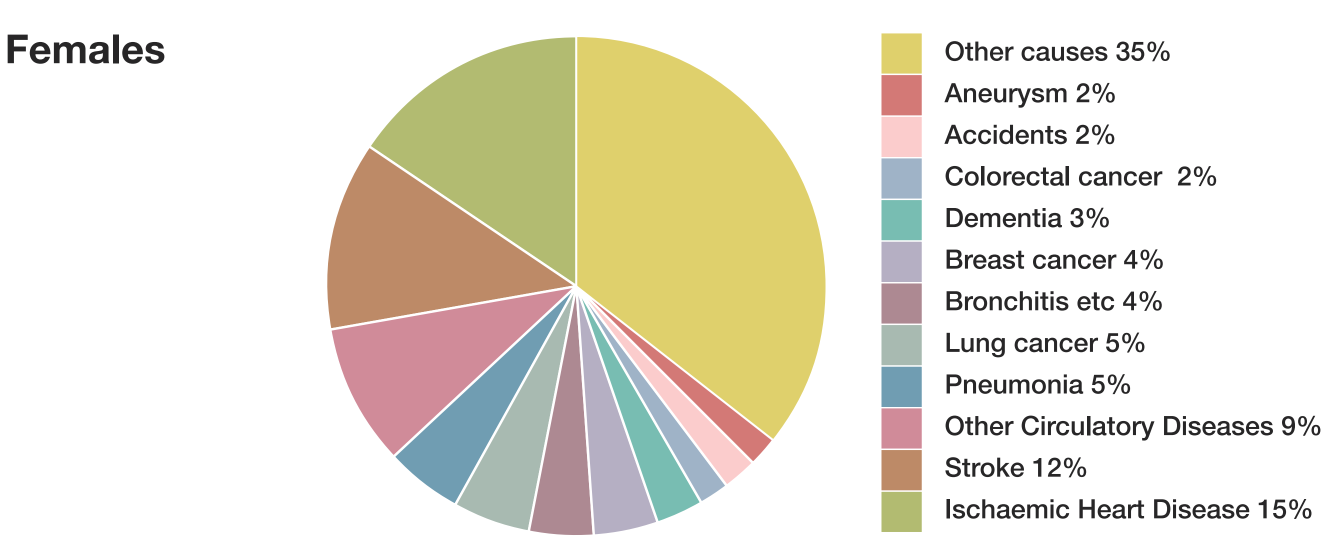
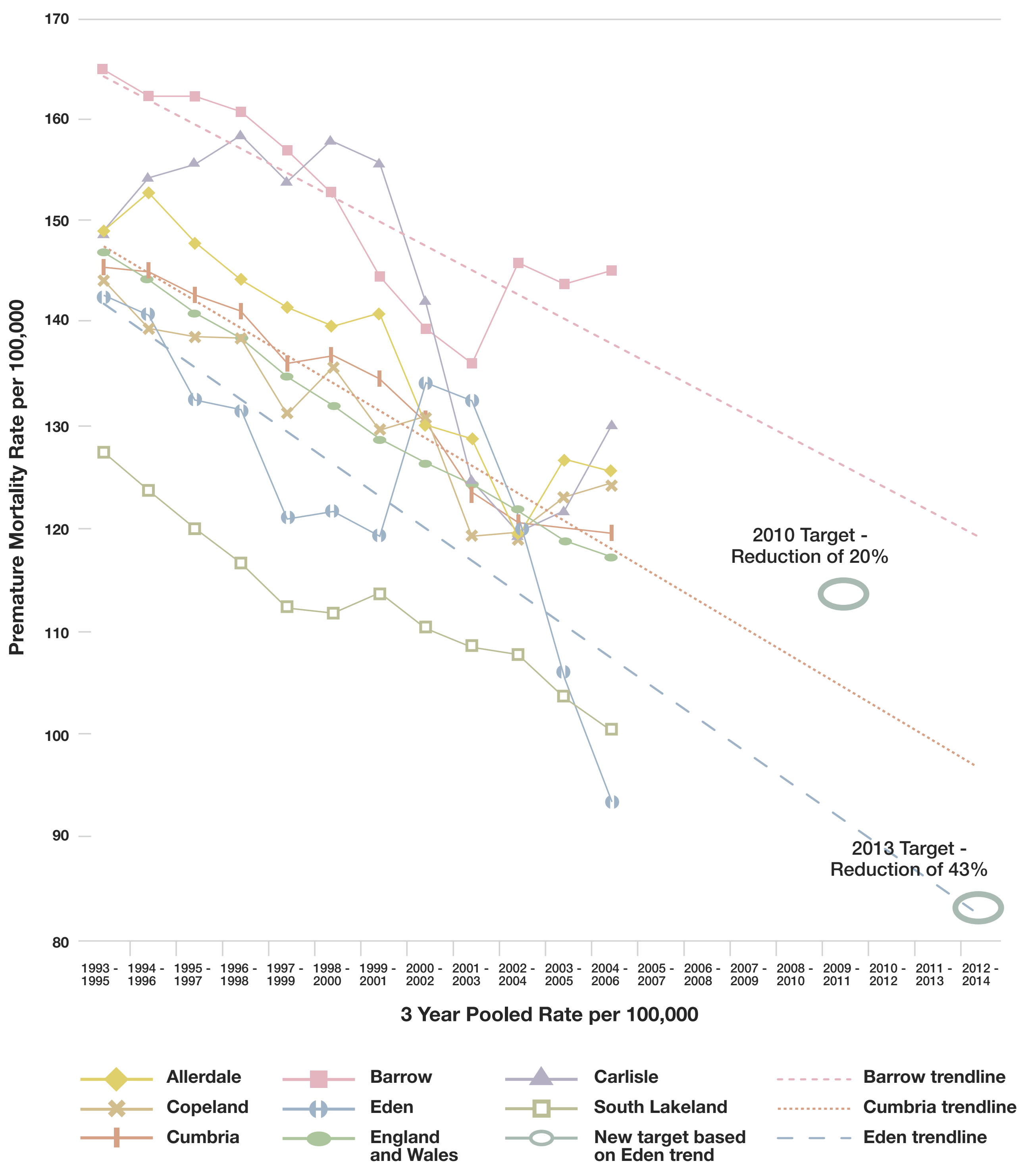
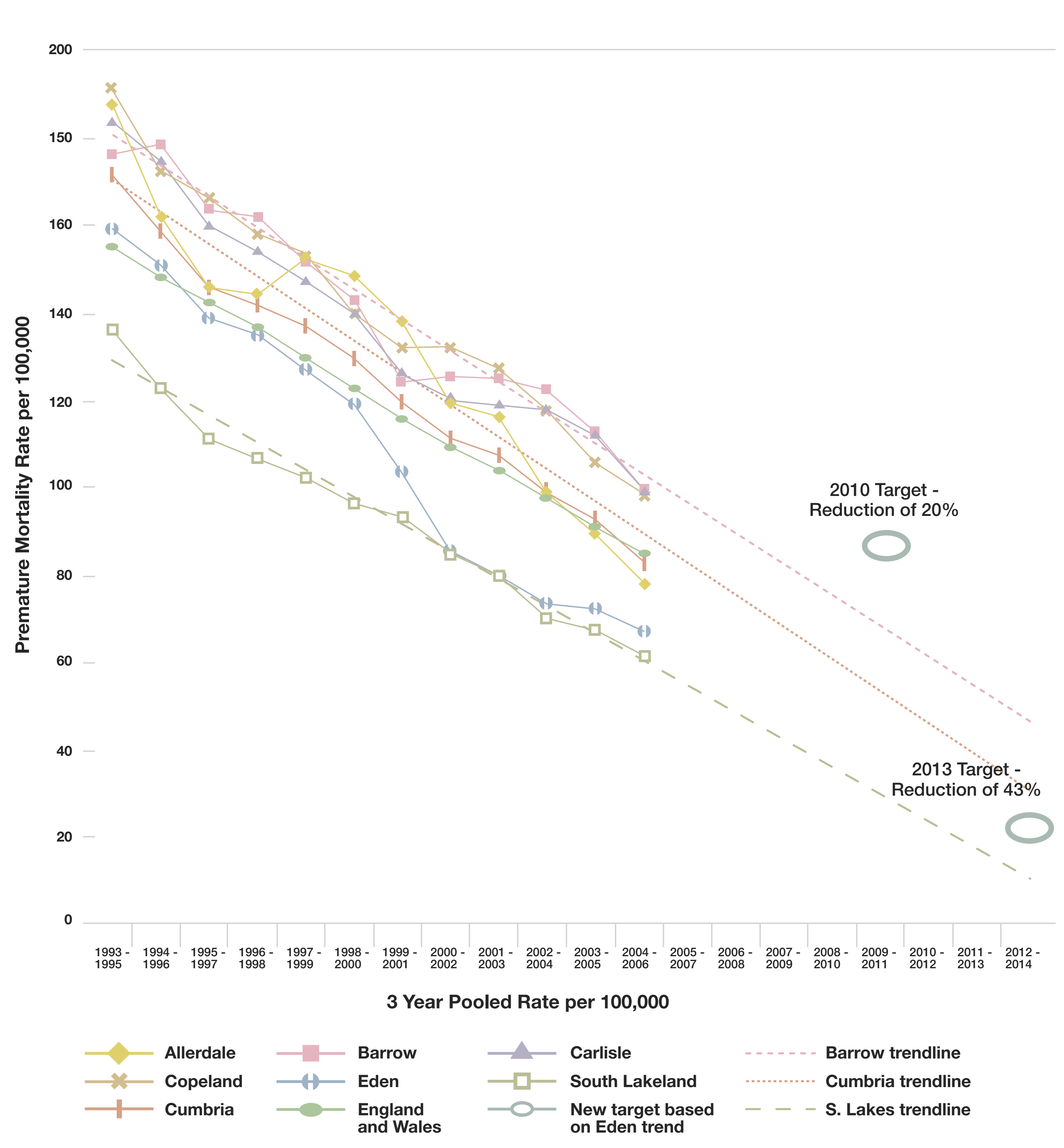


Figure 5: The directly standardised rate per 100,000 for residents dying of cancer aged 75 years and under: England and Wales in comparison to Cumbria and the six districts. Source: National Clinical Outcomes Database (NCOD).



Section 2:

Figure 6: The directly standardised rate per 100,000 for residents dying of circulatory disease aged 75 years and under: England and Wales in comparison to Cumbria and the six districts. Source: NCOD.



Unsurprisingly, there are huge variations between different areas in Cumbria. Figure 5 shows the mortality rate for cancer for Cumbria and each of the six districts. The chart shows that there is a significant gap in premature death rates for cancer between the best performing district (Eden) and the worst (Barrow). The most recent data shows that this gap is currently widening.

The chart also shows that, on current trends, Cumbria overall should meet the government's national target for 2010 of reducing the premature cancer mortality rate by 20%. However, some areas such as Barrow are not achieving as well for this target.

In Cumbria, circulatory disease (especially coronary heart disease) is, along with cancer, a priority as the second main cause of ill health. Mortality rates are above the national average. As with cancer, the highest mortality rates in Cumbria are also experienced in the most deprived communities of Barrow, Carlisle and parts of West Cumbria. Figure 6 shows that there is a significant gap in the premature deaths rates for circulatory disease between the best performing district (South Lakeland) and the worst (Barrow). However, the gap does appear to be starting to narrow.

A major factor in the prevalence of cancer and coronary heart disease is the differences in people's lifestyles and socio-economic backgrounds. An estimated 22,300 people (32% of the adult population) living in quintile one in Cumbria (the most deprived 20% of the population) are smokers, compared with only 10,200 (21%) in quintile five (the least deprived 20% of the population).

On average each year in Cumbria, over 900 people die because they chose to smoke. Smoking is linked not only with lung cancer, it also plays a part in other cancers, including:

- Bladder cancer
- Kidney cancer
- Stomach cancer
- Pancreatic cancer
- Oesophageal cancer

It can also lead to deaths from chronic obstructive pulmonary disease, pneumonia, heart disease and stroke.

With regard to alcohol consumption; a recent study undertaken by NHS Cumbria on hospital admissions for people with alcohol specific health problems showed that 2,440 people (almost 3% of the population) in quintile one (the most deprived 20%) had been admitted to hospital with an alcohol problem. This compares with 360 people (less than 1% of the population) in quintile five (the least deprived 20%).

Alcohol kills. Certain deaths such as alcoholic liver disease are wholly attributable to alcohol. However, alcohol also contributes to some cancer deaths, including colorectal, female breast, stomach and cancers of the oesophagus. Some deaths from stroke, heart disease and even epilepsy can be due to alcohol. There are also some obvious causes of death from alcohol: road injuries, accidents and falls. Alcohol also plays a contributing role in many suicides. In terms of premature deaths, alcohol was responsible for 13% of the total, accounting for some 230 people.

Alcohol can also have an extremely damaging impact on wider society through domestic violence, anti-social behaviour, fear of crime and days lost to the economy through sickness.

Section 2:

NHS Cumbria has set out an ambitious strategic plan for improving health outcomes over the next five years (www.cumbriapct.nhs.uk). This contains specific targets for reducing health inequalities.

NB The targets are shown in the box on page 25 and on the charts in figures 5 and 6.

It also sets targets for reducing the impact of some of the negative lifestyle issues which are major contributors to poor health, smoking, drinking and obesity.
The strategic plan was assessed by the Department of Health using a RAG (red/amber/green) process and the plan for Cumbria was given the top rating of green. This gives confidence that the targets for improving health can be delivered. Indeed, NHS Cumbria has ranked fourth highest in a national league table of PCTs and joint first in the North West region.

The health inequalities and smoking targets are also part of Cumbria's Local Area Agreement, which ensures partnership support for delivery (see Section 6).

The scale of the challenge in Cumbria is enormous and matches that of many urban centres in the UK and wider world. However, there are many simple and practical things we can do. In addition to the work outlined in the strategic plan, I would also like to see the public sector using its powers more creatively. Proposals for a local smoking ban in Liverpool sparked a widespread debate which eventually led to bans in Scotland and Wales then, finally, a ban in England in 2007.

In Cumbria, I would like to see local authorities investigate the greater use of their wellbeing powers and assess whether they could make imaginative local bylaws to improve health and wellbeing. This could mean, for example:

- Using licensing powers to refuse licences to pubs and other establishments who persistently abuse a code of practice through happy hours and other marketing which encourages excessive consumption of alcohol.
- Using planning powers more creatively to reduce the number of new fast food outlets near schools and hospitals and to ensure planning gain is used to promote health through cycle paths or play areas in housing and commercial developments.
- Imposing greater restrictions on tobacco outlets.

Recommendation 1

I recommend that the local authorities in Cumbria investigate making greater use of their wellbeing powers and assess the extent to which they could make imaginative local legislation through bylaws to improve health and wellbeing.

Reducing inequalities: coronary heart disease and lung cancer

By 2013, we will have reduced the gap in life expectancy between the most deprived and the most affluent communities in Cumbria in the priority diseases of coronary heart disease and lung cancer:

1. There will have been a reduction in the variation in premature mortality due to cancer between the worst and best performing districts from the current 51.8 per 100,000 figure (2004/06) to 41.4. We aim for all six districts to reach the target of 82 premature deaths per 100,000 by 2013.

2. There will have been a reduction in the variation in premature mortality from circulatory diseases between the worst and best performing districts from the current 37 per 100,000 figure (2004/06) to 22.3. We aim for all six districts to reach the target of 23 premature deaths per 100,000 by 2013.

Reducing inequalities: smoking, obesity and alcohol misuse

By 2013, we will have reduced smoking, obesity and alcohol misuse, which give rise to poor health (particularly coronary heart disease and cancer) and wider problems within our community:

Alcohol reduction

i. There will have been a reduction in the rate of hospital admissions per 100,000 for alcohol related harm, from 1,914 to 1,800 per 100,000 [WCC OM 42].

ii. There will have been a reduction in the number of lives lost annually which are directly attributable to alcohol misuse from 58 to 45 by 2013.

Smoking reduction

i. There will have been a reduction in smoking rates from 24% of the adult population to 21% by 2013 [WCC OM16].

ii. There will have been a reduction in pregnant mothers recorded as smoking at the time their baby is delivered from 19% to 9.5% by 2013.

Obesity reduction

i. We will have halted the rise in childhood obesity, with no more than 10.1% of reception children and 15.7% of Year 6 assessed as being obese by 2013.

ii. We will have halted the rise in adult obesity, with no more than 25% of the adult age population assessed as obese by 2013.

Section 2:

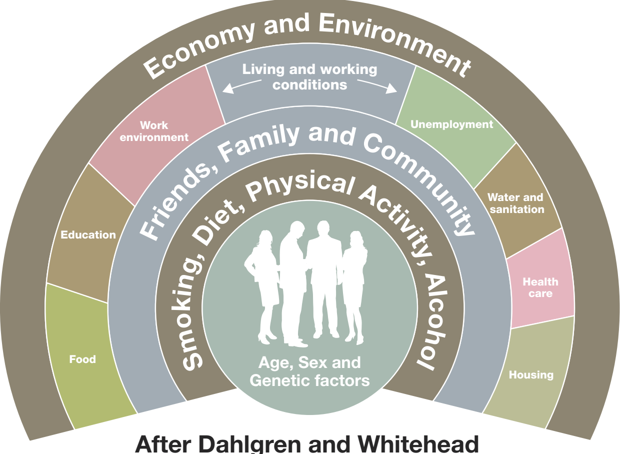
Wider determinants of health inequalities

Good health arises through a complicated interaction of many factors including genetics, lifestyle choices and the environment. Some, like genetic factors, cannot easily be changed. Others are related to lifestyle factors such as smoking, diet, physical activity and alcohol. But an individual's health is not solely determined through their lifestyle choices. It will also be related to the quality of family life, educational attainment, employment, workplace conditions and housing. Figure 7 shows the links between these determinants of health.

This wider impact has been recognised by the Government. In addition to the headline Public Service Agreement (PSA) target to reduce inequalities in health outcomes by 10%, as measured by infant mortality and life expectancy at birth, the 2003 Programme for Action to tackle Inequalities in Health also set out 12 headline indicators to assess progress and improvements towards the national target.

Based on these headline indicators, how is Cumbria faring? Overall there is only one indicator – the number of homeless families – that is not improving (figure 8). Unfortunately, for five of the indicators we do not have sufficient data to establish a trend. Although the number of teenage pregnancies in Cumbria is going down, the decrease is disappointingly small and nowhere near the challenging targets set nationally for reductions in teenage pregnancies.

Figure 7. Determinants of Health



After Dahlgren and Whitehead

But this data is only giving the story for Cumbria as a whole county and I have already highlighted the vast differences in health between communities. In order to really monitor progress towards reducing health inequalities in Cumbria, we need to track the progress on these indicators between different communities. I have already shown in figure 6 (page 22) the big difference in premature death rates from circulatory diseases when one compares the six local authority areas in Cumbria. South Lakeland and Eden have much lower death rates than Barrow and Copeland and there will be similar differences between our communities for all these indicators.

Working with our partners at Cumbria Intelligence Observatory, we will concentrate on developing our local information systems so that we can measure health in our communities as well as at county level.

What more can be done? There are clear programmes in place, many supported by excellent partnerships, to tackle some of wider determinants of health inequalities, such as worklessness, poor educational attainment, crime and anti-social behaviour.

Figure 8: Health inequalities in Cumbria: national headline indicators

	Cumbria			National Trend
National Indicator	**Baseline/Earlier data**	**Current position**	**Trend**	
The big killers under 75 years: Circulatory disease	146 deaths per 100,000 100,000 population	77 deaths per 100,000 population	☺	☺
Cancer	143 deaths per 100,000 population	116 deaths per 100,000 population	☺	☺
Teenage pregnancy (under 18s)	42 conceptions per 1,000 teenage girls	40 conceptions per 1,000 teenage girls	☺	☺
Road injuries and deaths	150 per year	121 per year	☺	☺
Primary care services	67.5 GPs per 100,000 population	68 GPs per 100,000 population	☺	☺
Flu vaccination: over age 65	75% protected	75% protected	☺	☺
Smoking: Prevalence	😐	24% smoke	😐	☺
Smoking in pregnancy	😐	19% of mothers smoke	😐	☺
Educational attainment (5 GCSEs at A*-C)	53% children	60% children	☺	☺
	21% children receiving free school meals	34% children receiving free school meals		
Fruit and vegetable consumption (five or more portions per day)	😐	27% of adults	😐	☺
Poor housing	😐	666 families living in non-decent housing	😐	☺
PE and school sports	83% participation in PE	90% participation in PE	☺	😐
Child poverty	😐	15,000 children living in poverty	😐	☺
Homeless families	77 families	156 families	☹	☺

☺ data moving in right direction however certain targets may not be achieved

☹ data moving in wrong direction

😐 insufficient data available to determine a trend

Case study 1:

Worklessness in Barrow and West Cumbria

It is generally agreed that work is good for your heath and that being in good health helps you stay in work. People who have long term conditions or a disability often find it harder to stay in, or return to, employment and people's health tends to decline the longer they are out of work.

This relationship between work and health can result in a rapid increase in health inequalities. People in disadvantaged social circumstances are more likely to develop chronic health problems. These people are also particularly likely to lose their jobs and find it difficult to get back into work because of their health. This puts them at risk of further economic hardship, which can further worsen their health and so exacerbate health inequalities.

We are particularly worried about this in Cumbria because there are a large number of people out of work because of their health, with just over 23,000 people claiming incapacity benefits; about 8% of the working age population.

This is partly a result of the industrial history of Cumbria and the high rates found in Barrow and West Cumbria. However there are still large numbers of people who are leaving the workforce each year, or who have never worked, ending up with long term incapacity.

The current economic downturn is likely to increase this trend, as people with long term conditions are the most at risk of losing their jobs. The NHS has an important role to play in helping people with long term conditions stay in or get back to work. For someone who is finding it difficult to go to work because of their health, the first point of call is their GP. In Cumbria in the last year nearly 30,000 people will have been issued with a sickness certificate by their GP and about 1,500 of these people will subsequently end up on incapacity benefits.

We know that, to help keep people who are experiencing health problems in work, we need to act as early as possible. Several reviews of the evidence have found that, to be effective, we need to provide three kinds of support. Firstly, support from health professionals to address both the physical and psychological barriers to work; secondly occupational health support to address occupational and organisational barriers; and thirdly advice on job skills, training and welfare services.

In Barrow, we are now putting together these three elements as part of a pilot project supported jointly by Job Centre Plus and NHS Cumbria. At present a Job Centre Plus employment advisor runs sessions in GP practices each week. Where a GP is seeing a patient who is out of work or experiencing difficulties with work because of their health, they can refer them to the employment advisor. The advisor then helps them with confidence building, training opportunities, job search skills and advice on welfare benefits.

Together with Cumbria Partnership Trust and Job Centre Plus, we are developing a package of support for people absent from work due to illness as part of the Condition Management Programme. This will be provided by a multi-disciplinary team including an employment advisor, mental health workers, physiotherapists and an occupational health specialist who will work with the individuals, their employer and their GP to facilitate a progressive return to work.

Section 2:

The target for improving health inequalities is a key indicator in the Local Area Agreement for the county – the Cumbria Agreement. This is supported by other targets to tackle health-related issues (such as stop-smoking targets) and targets to address the wider determinants of health inequalities (such as educational attainment, worklessness, and affordable housing).

However, whilst I am heartened by the partnership focus on the wider determinants, I am concerned that many of these measures are county-wide and there is no means of specifying or assessing the targeted impact on our most deprived communities. The Local Area Agreement (LAA) is a three year agreement but refreshed annually. I believe that, at the next refresh, partners should build in targets and actions which clearly show how we will 'level-up' the outcomes for the key determinants of health inequalities, such as education and housing, in deprived areas to those of the best in the county. They should also make explicit cross-cutting actions that are needed to make real progress (getting out of silos).

Recommendation 2

I recommend that at the next refresh of the Cumbria LAA, the Cumbria Strategic Partnership should ensure that partners build in targets and actions which clearly show, for the key determinants of health inequalities, how we will 'level-up' the outcomes in deprived areas to those of the best in the county. They should also make explicit cross-cutting actions that are needed to make real progress (getting out of silos).

I am pleased that the issue of housing - especially affordable housing - is a key priority in the LAA. However, I am concerned that there is no concrete evidence regarding the overall state of private sector housing in Cumbria and the extent to which it is likely to meet future need in its widest social sense. Although there have been studies in some areas, these are by no means comprehensive, consistent and carried out on a regular basis to allow the public sector to assess whether sufficient improvements are being made.

We also need to consider the impact which the change in demographics, particularly the ageing population, will have on our housing stock. We need to plan now for a "lifetime homes" agenda so we do not see the upheaval of older people leaving their homes for residential or nursing care provision or a shortage of decent housing stock, adapted to an ageing population.

Recommendation 3

I recommend that the housing authorities in Cumbria take urgent steps to ensure that a comprehensive and consistent private sector housing conditions survey is carried out on a regular basis and linked more effectively to strategic planning (eg for "lifetime homes" planning for future needs and an ageing population; transport planning; and for supporting integration of services at supra-parish or local area partnership level).

Health inequalities and the impact on minorities

Ethnic population levels in Cumbria are, at 0.7%, much lower than the average for England and Wales of 8.7%. There is an even spread of minority groups across the county, with no particular concentration in any geographical area. There has been significant immigration into Cumbria from non-UK nationals, primarily from Poland.

This immigration is predominantly associated with the tourist sector in the Lake District, agriculture in rural areas and the sea food industry on the coast. Aside from this immigration, population forecasts do not show a significant increase over the next five years.

The small percentage of Black and Minority Ethnic (BME) communities in Cumbria makes it statistically difficult to assess whether there is an adverse impact on ethnic minorities from any particular aspects of ill health.

Section 2:

Although there is some excellent operational work undertaken, especially working with gypsies and travellers, I believe that we need to improve our information systems to help us better ensure that our strategic approach is supporting all people in Cumbria.

Recommendation 4

I recommend that NHS Cumbria and the County Council, working through the Cumbria Information Observatory, set up systems to assess whether there is an adverse impact on health among Black and Minority Ethnic (BME) groups in Cumbria and, if so, to give positive recommendations on the issues to be addressed.

Health inequalities and children and young people

Health inequalities are unacceptable, no matter who is affected by them. But most people would agree that the impact on children and young people is a particular blight which must be eradicated in a modern post-industrial society.

Nationally, the proportion of children living in low-income households in England has fallen since the baseline of 1998-99, but is still above Government targets.

In Cumbria we do not have directly comparable data to the statistics for England. The Income Deprivation Affecting Children Index (IDACI) from the Index of Multiple Deprivation (IMD) 2007 covers children aged 0-15 years living in income deprived households (households in receipt of various government benefits). In Cumbria there are approximately 15,000 (16%) children aged under 16 years living in income deprived households. This is lower than the national average of 21%.

However, within Cumbria both Barrow-in-Furness (23%) and Copeland (21%) have a higher proportion of children living in income deprived households than the national average. Eden and South Lakeland have the lowest proportion at 9%.

Much of national and local government policy is directed at reducing this further and there are many examples of good practice in Cumbria. See case study 3 on tackling obesity in children and young people.

However, with the potential for a major recession affecting western economies, there is a real danger that these levels will become worse rather than better unless concrete action is taken.

I feel that more could be done to positively target support to those families in the deprived areas through an integrated approach across all national and local public sector agencies. I would like to see the Cumbria Strategic Partnership taking the lead in bringing partners together to pilot innovative approaches to reducing the impact of inequalities on children.

Recommendation 5

I recommend that the Cumbria Strategic Partnership takes the lead in bringing partners together to pilot innovative approaches to reducing the impact of inequalities on children. A concrete example is organised activities for children and young people in holidays which are entertaining, can build social and other skills and can divert them from possible anti-social behaviour.

Case study 2:

Work to improve health of Gypsies and Travellers in Carlisle and Appleby

Cumbria has a large Gypsy and Traveller population with authorised encampments in Carlisle, Penrith and Barrow and a further authorised Traveller site planned in Carlisle for 2009.

There is startling evidence of inequalities in the health of Gypsies and Travellers compared to even the most disadvantaged sections of our population.

In Cumbria we identified that there is also a widespread lack of understanding about the Travelling way of life.

During 2008, NHS Cumbria engaged three Gypsy Roma men to deliver two awareness raising seminars for key primary care and local authority staff. The seminars aimed to raise awareness of specific issues relating to the Gypsy and Traveller population and to build capacity for improving the health and wellbeing of this group.

The seminars were led by Richard O'Neill, a well-known speaker from the English Gypsy Roma community, with input from two Gypsy Roma men, one of whom is currently receiving treatment for cancer and one for diabetes.

The seminars included a history of Gypsy Roma Traveller communities as well as cultural, health, accommodation, education and employment issues. Examples of good practice and practical solutions for overcoming barriers and improving uptake of services to Gypsy Roma Traveller communities were also identified.

Overall the message Gypsies and Travellers gave us was "to work with them and not for them".

The result has been an enthusiastic response to working with Traveller groups and a number of pieces of work are being taken forward. One major development is that one of our local Travellers has now qualified as a Stop Smoking Advisor and is currently enrolled on a Health Trainers Course. She is supporting her fellow Travellers to improve their health and wellbeing with the skills she is developing.

Case study 3:

Tackling obesity in children

Tackling overweight and obesity in children is a public health priority. Almost one in four reception year children in England are overweight or obese. In year six this figure rises to one in three.

Overweight children can suffer from a number of both physical and emotional health problems. Over half of obese children grow up to be obese adults.

The MEND Programme (Mind, Exercise, Nutrition, Do It!) was developed by University College London Institute of Child Health and Great Ormond Street Hospital for Children NHS Trust. It is a free of charge, community based, 10 week programme for children and their families. The overall aim is to encourage participants to change unhealthy attitudes to food and eating (Mind), motivate families to participate in regular exercise (Exercise), enable them to make informed food choices (Nutrition) and to sustain these improvements (Do It!).

The ten week programme in Carlisle is delivered by Carlisle Leisure Ltd in partnership with Carlisle City Council and supported by NHS Cumbria.

A recent evaluation of 14 children aged 7-14 years, who were enrolled on the local MEND programme, found that the participants lost an average of 1.3 kg and grew 1.3 cm, indicating an average reduction in body mass index from 29.5 to 28.3. The average group waist circumference was reduced by 4.2 cm. Improvements in physical fitness were demonstrated with a reduction in heart rate recovery following aerobic exercise of 10 beats per minute after three minutes. The results also indicate that participants increased their physical activity throughout the weeks of the course and decreased time spent in front of the television or computer. Improvements in eating habits and nutritional choices were demonstrated. The MEND Programme has confirmed its potential to have a positive impact on the health and wellbeing of our local children through a range of family interventions that are good fun as well as educational.

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Section 3:

The Demographic Challenge

In this section I look at the demographic challenge facing Cumbria, the ageing population, the declining number of young people and the problems and opportunities which this brings.

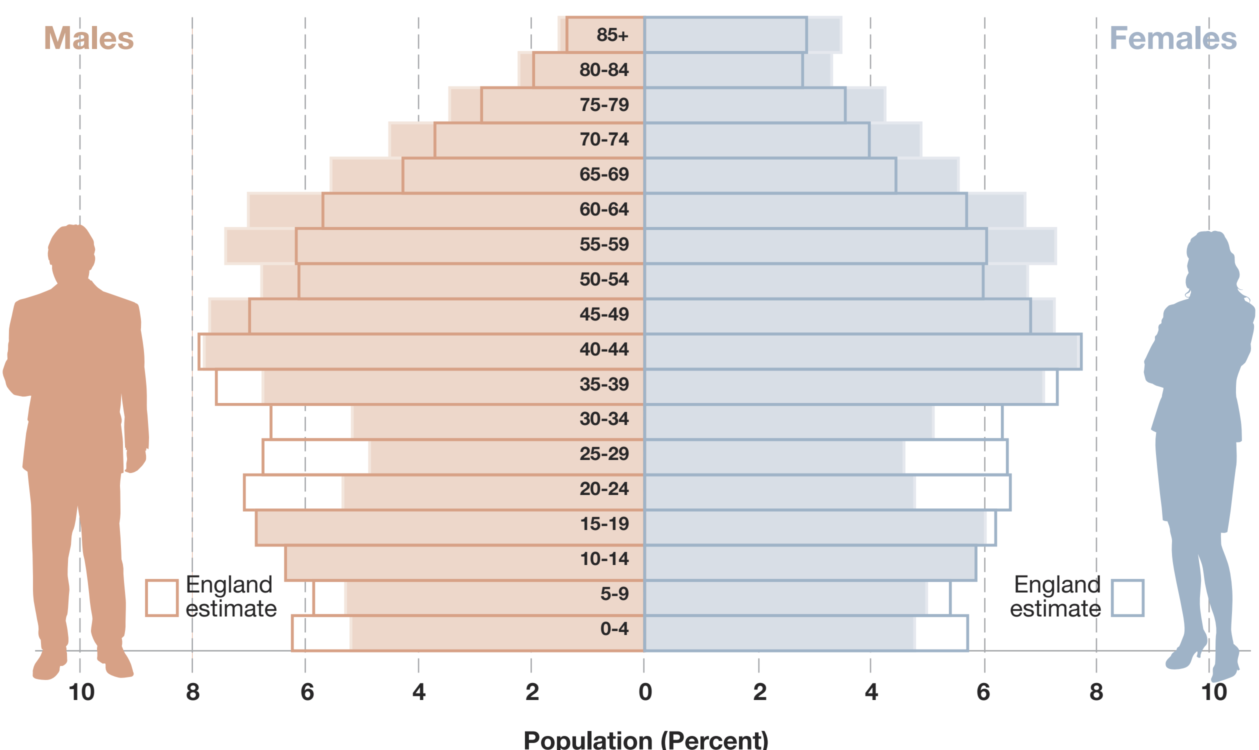
Cumbria's population

The first demographic transition began around 200 years ago, as a consequence of the industrial revolution in Britain, with the movement of masses of people from the countryside to the towns. This was characterised by explosive population growth fuelled by high birth rates, cheap food and a decline in the number of infant deaths as a result of public health reform.

The western world is now facing a second transition, with an increasingly aged population and a decline in birth rates caused by low levels of infant mortality and the contraceptive pill, which provides women with choice over when and if they have children.

The latest mid-year estimates for 2007 show that the population of Cumbria is 496,900. Of this total, 16% (80,100) were aged 0-14 years, 65% (320,700) belonged to the 15-64 age group and 19% (96,100) were over 65 years of age. When comparing the Cumbrian age profile to that of England (Figure 9), it can be seen that Cumbria has an older population. There are approximately 16,600 more people

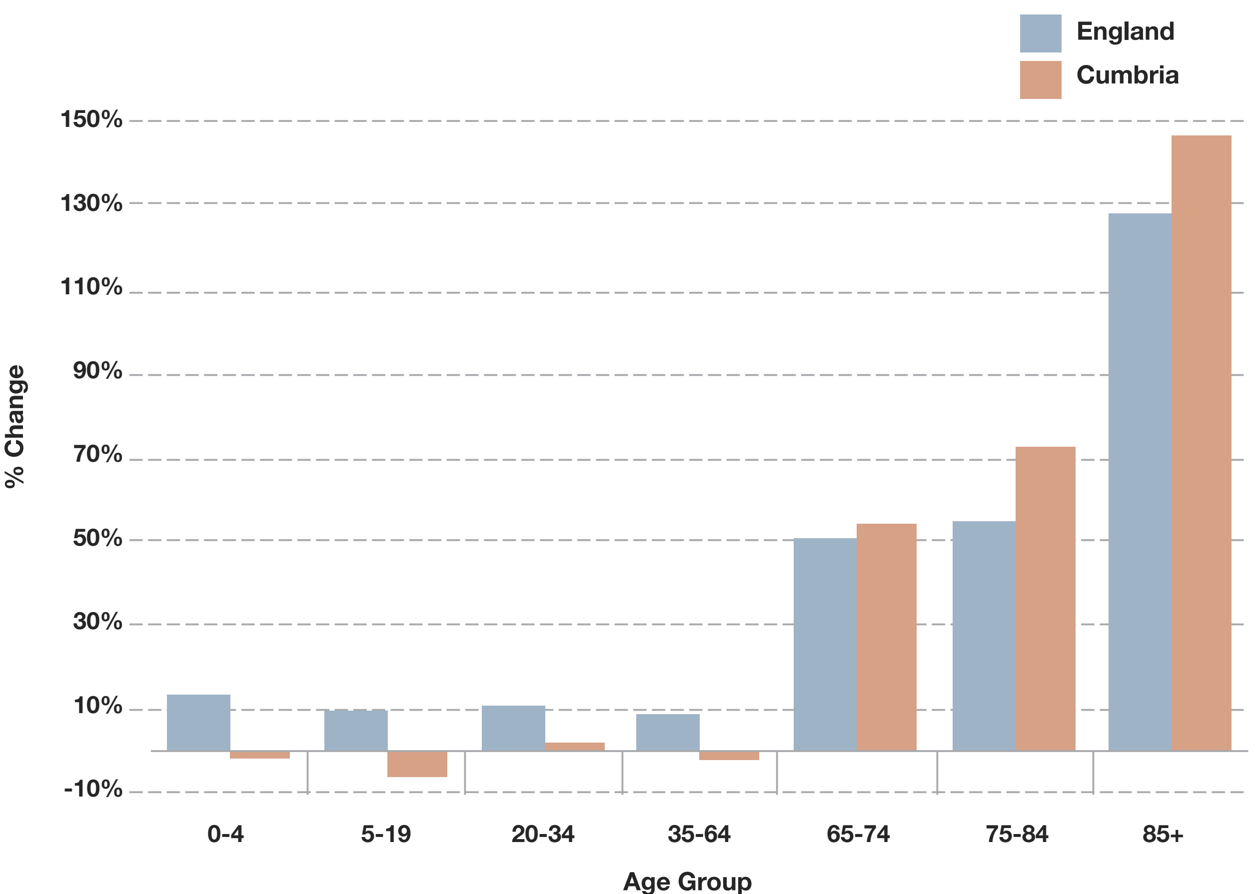
Figure 9: Cumbria and England Mid-2007 Population Estimates. **Source: ONS.**



over 65 years of age living in Cumbria than one would expect given the England age profile.

The most recent population projections show that by 2031 Cumbria's population will have grown by 13% to 560,200. Projections show that the county will have an increase of 69,800 people aged 65 years and over and a decrease of 5,600 in those aged below 65. Of this decrease, there will be 3,700 fewer young people aged 19 or under, in contrast to increases nationally in under 19s. See figure 10.

Figure 10: Change in population 2006 – 2031



Section 3:

The growth in the population is not evenly spread across the county. There will be an 18% increase in Carlisle and only a 6% increase in Barrow-in-Furness. See figure 11.

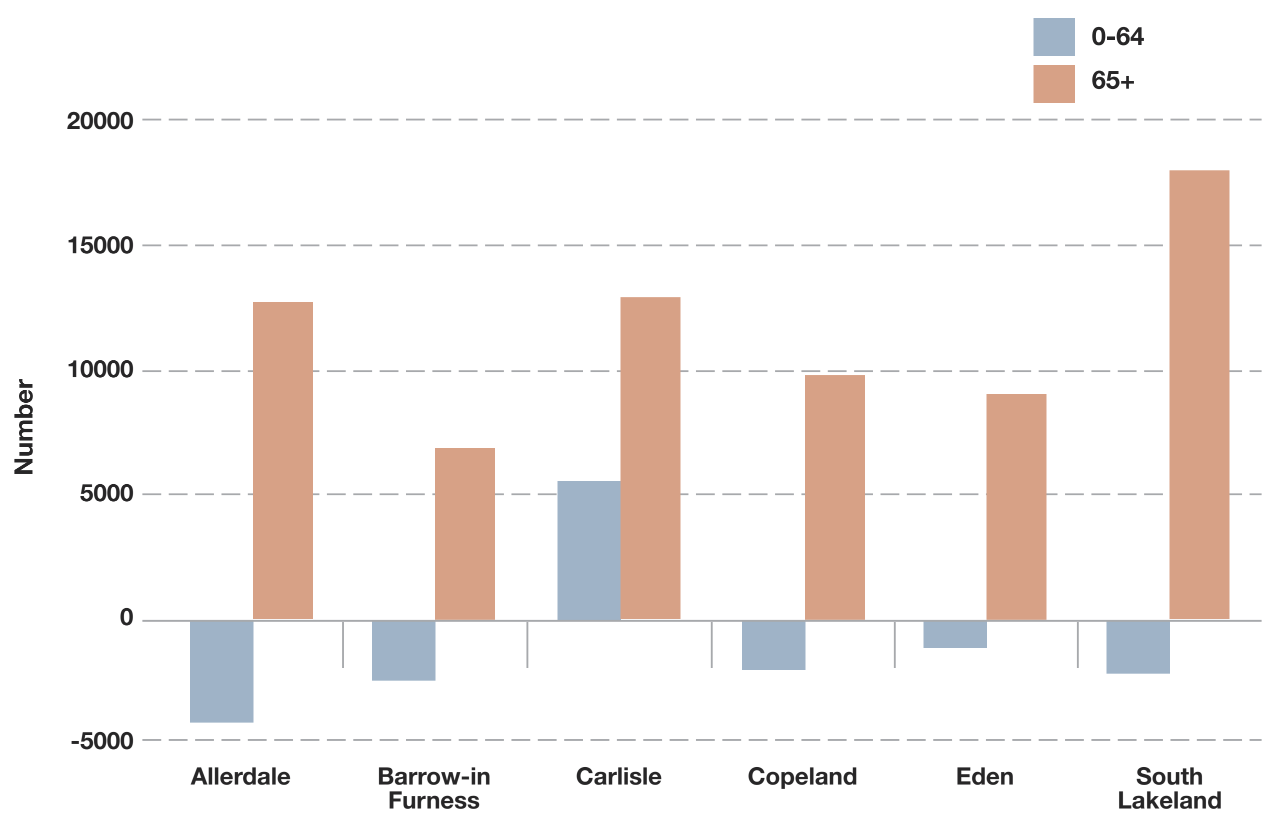
Paradoxically, in Cumbria (especially in South Lakes and Eden) there are more deaths than births each year but the population is still increasing. This is as a result of the combined effect of retirees entering the county and people living longer once here.

A much larger and older population will create a greater demand for personal health and social care at a time when there are less people of working age to provide it.

More older people living longer will also mean a qualitatively different level of need. For example, unless action is taken now, over the next 20 years Cumbria will see:

- An 82% increase in dementia.
- An estimated 60% increase in hospital admissions for stroke.
- The number of people supported for social care needs will increase by 25%, equivalent to 198 more nursing home beds (4 new homes); 459 more residential care beds (9 new homes); and 330,000 home care hours a year (130 more full time home carers).

Figure 11: Change in population 2006 to 2031 by district



Case study 4:

Keeping warm and well in South Lakeland

Rising fuel prices, rural isolation and an ageing population contribute to making fuel poverty and fuel efficiency a particular issue for South Lakeland. In response, a series of events took place during winter 2008/09 aiming to increase awareness of fuel poverty. Local residents were provided with advice about local services, available grants and practical solutions and energy saving measures to help save money and keep warm.

The first of these events was a 'Quick Steps to Energy Efficiency' tea dance, hosted by South Lakeland District Council. Over 100 older people attended and received 'Keeping Warm and Well' resource packs, funded by NHS Cumbria, containing a thermo mug, energy saving light bulbs, carbon monoxide detectors, room thermometers and information leaflets.

Ironically, attendance at two other events hosted at Windermere and Sedbergh fire stations in December, were adversely affected by hazardous winter weather. Despite this, about 30 people attended each event. A further event targeting families took place at Kendal Fire Station in January 2009.

As a result:

- The Fire Service had 88 referrals for 'Home Fire Safety' checks.
- The Pensions Service had 49 enquiries and eight home visits resulting in three attendance allowance claims, three pensions' credits claims and two council tax benefits claims. Following a referral, one resident will be £500 per annum better off through council tax benefit and is having a home visit to assess other eligibility.
- Five people organised a visit from the council's handy person scheme.
- South Lakeland District Council received 15 insulation grant applications and one resident has received a home improvement grant to replace his defective storage heater, which was his main form of heating.

The events were coordinated by the 'Successful Ageing' sub group of South Lakeland Strategic Partnership's Health and Well Being Task Group. Partners included NHS Cumbria, Age Concern South Lakeland, Cumbria Fire and Rescue Service, Signposts, South Lakeland Carers, South Lakeland District Council, South Lakes Society for the Blind and the Pension Service.

Given the changing demographics in Cumbria, it is important that we focus attention on the increase in the elderly population. However, it is also important that we focus too on children and young people.

As the numbers decline it is vital that we provide a supportive and positive environment for our young people, in particular giving them a sense of hope and the enthusiasm to stay in the county. To do this, we need to ensure there are sufficient opportunities for jobs, housing and cultural activities. We also need to encourage families to return or move to the county because this is an area with good childcare, excellent education and low levels of crime.

Section 3:

What should be done to help meet this challenge?

To meet this challenge, I believe we need to focus on five things:

1. Help keep people fit and well for as long as possible

As figures 2 and 3 showed, it is not just how many years one lives, but how healthy those years are. The increasingly 'risk taking' attitude of young people, especially in relation to alcohol, means we are seeing ill health problems such as liver disease, which used to be experienced in middle age, now being seen in their 20s and 30s.

At the other end of the spectrum, many people view illnesses such as diabetes and dementia as inevitable in later years. This is plainly not so. We need to find ways to support people in making the right choices for a long and healthy life.

2. More self –management of care to promote independence for as long as possible

In many communities, there is a fatalistic view of the NHS that it is there to fix you when you are broken. This is typified in the "doctor knows best" philosophy. We need to encourage 500,000 expert patients in Cumbria to take control of their own health and wellbeing.

This can include a simple "know your numbers" approach, so that people know what their healthy weight, blood pressure, cholesterol figures etc should be and actively monitor and manage them. We can also empower people with long term conditions such as diabetes to specify the menu of treatment that they believe is most appropriate for their circumstances, rather than simply being told by the doctor what to do as part of a "year of care" approach.

3. Capacity building in our villages, towns and city

We need to give people the confidence and the tools to build and maintain healthy and vibrant communities for all, as they have done at Crossthwaite and Bolton. See case study 5.

4. Positive strategies across all public sector agencies for older people

This could include changes in integrated health and social care teams to meet ageing diseases such as diabetes and dementia.

5. Provide positive opportunities for children and young people.

In line with this, I greatly welcome the formation of the Children's Trust and the development of a Children and Young People Strategy. As my post is a joint appointment across the county council and primary care trust (NHS Cumbria), I will aim to ensure that the health service plays an active and positive role in improving the health and wellbeing of all children and young people in our county.

I also believe that we need to link fuel poverty with the green agenda and sustainability. Cumbria leads the nation in terms of renewable energy for commercial production, but we need to establish initiatives whereby communities (particularly the elderly, vulnerable and those at risk of deprivation) take advantage of sustainable local sources of power such as wind, hydro-electric, geo-thermal or wood boilers, supported by initiatives on improving housing stock through greater insulation. Initiatives of this type would encourage job creation and support the wider economy.

Recommendation 6

I would like to see positive approaches to tackling fuel poverty which also give the opportunity for job creation through greater harnessing of renewable energy for heating homes.

I firmly believe in the Wanless 'fully engaged scenario' as being essential if we are to build a sustainable health system capable of significantly improving health outcomes in Cumbria. In a time of financial stringency, it is of even greater importance that we mobilise Cumbria's natural resources – its people – to protect and improve health. I recommend that we work together across public, private and third sectors to develop a comprehensive approach to asset mapping and utilisation.

Recommendation 7

A capacity building strategy based on mapping community assets should be explored with some urgency by public, private and third sectors, co-ordinated through the Cumbria Strategic Partnership.

Case study 5:

Successful ageing community exchanges project

The success of a scheme in the South Lakeland village of Crosthwaite has prompted NHS Cumbria and partners to lend their support to setting up more ‘community exchanges’ in rurally isolated areas of Cumbria.

The Crosthwaite Exchange is a shining example of effective community action in the face of the loss of rural services. In 2005, Crosthwaite’s shop and Post Office closed and the villagers realised that they no longer had a central point where local people could meet to exchange news, views and concerns, or to learn of others who may need help and support through meeting on a weekly basis.

The idea of opening a coffee shop once a week in the village hall was mooted, but with a ‘chic café’ feel rather than just a village coffee morning,and with an atmosphere that would attract all ages and encourage a real sense of community. ‘Run for the village, in the village, by the village’, as the Crosthwaite Exchange aim states.

Since then, the Exchange has gone from strength to strength. On average, over 60 people attend each week and the following services are offered:

- Café
- Country market with local produce
- Fish and meat ordering service
- Traidcraft (dry goods)
- Neat Feet foot care specialist service
- Manicurist
- Books, videos, DVDs and magazines
- Notice board
- Toys and crafts for young children

Although the Exchange is for all ages, there are particular benefits for older members of the community, who tend to be more isolated for a variety of reasons.

The success of the Crosthwaite Exchange has already led to a similar volunteer-driven project being set up at Bolton, near Appleby. As well as a café area, the Bolton Exchange includes lunch clubs and cultural activities including theatre trips and a proposed film club. There are weekly stalls with local produce including fish, meat, cheeses, chutney, jams and vegetables as well as a fair trade stall once a fortnight.

Particularly important to the village is the continued integration of children and young people with older residents. There is a children’s corner and occasional activities with the school and youth club, such as Christmas carol singing.

Although the loss of a key rural service acted as a catalyst to the development of both these Exchanges, there is no reason why the model should not be considered appropriate for any community seeking to reduce social isolation and improve access to local services.

The programme to support the development of exchanges is being taken forward by Action for Communities in Cumbria, working in collaboration with a range of partner organisations and community representatives.

The exchange support initiative forms one of the initial schemes being taken forward in a multi-agency programme of work called “Successful Ageing”, which is supported by the South Lakeland Local Strategic Partnership. The Partnership began developing this initiative in 2008, in response to the anticipated increase in the number of older people in South Lakeland over the next 20 years. A similar scheme is also planned for the Eden Valley

Section 4:

Re-orientating health and social care services to be closer to home in Cumbria

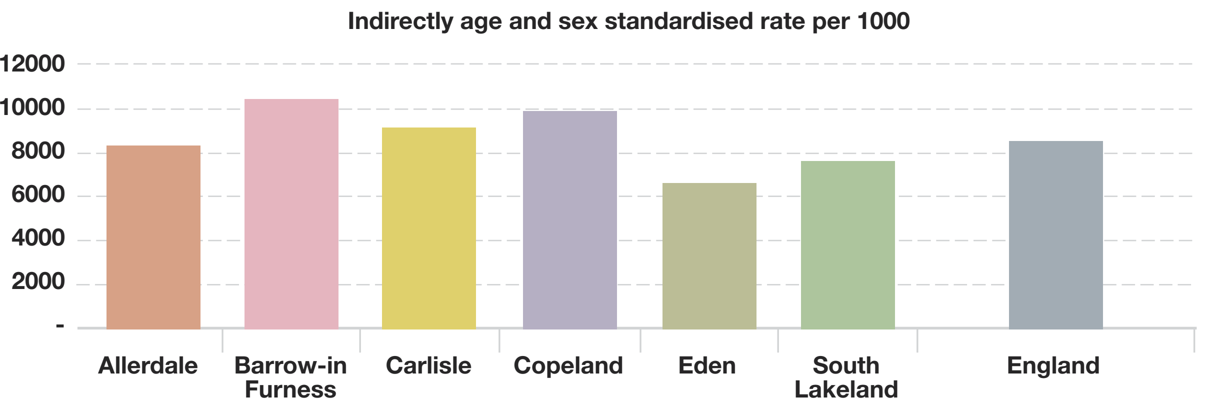
In this section I look at how we can improve health outcomes by re-orientating health and social care services to be closer to home.

In September 2007, NHS Cumbria launched a consultation on providing more services in primary care and in the community, closer to people's homes, in North Cumbria. This included the transfer of some services from the hospitals where they had traditionally been provided to more appropriate settings in primary care. This was based on five key objectives:

- We want to help more people keep fit and well for longer.
- We want to provide more services in the community by strengthening the capacity of community and primary care services, including providing local beds where necessary.
- We want to complement these local services with acute hospitals providing the specialist services that they are uniquely able to provide and to the standards of the best in the country.
- We want services to reflect local priorities, with local doctors, nurses and other professionals playing a greater role in setting local priorities.
- We want services which are more responsive to what patients and their families need, such as fewer and shorter admissions to hospital.

The consultation paper and subsequent Primary Care Trust Board decision-making report can be found at **www.cumbriapct.nhs.uk** NHS Cumbria and its partners are currently preparing proposals for consultation on Closer to Home in South Cumbria, to be undertaken later in 2009.

Figure 12: Emergency admissions for all conditions 2006/07



Section 4:

A key concern behind the Closer to Home proposals was the high level of admissions to hospital (both emergency and planned admissions) that people in Cumbria experience relative to the national rates as well as the long length of stays associated with these admissions. For example, figure 12 compares the rates of emergency admissions for each of the localities in Cumbria against the national average, for the latest available figures.

Figure 12 shows significantly higher rates of admissions in 3 out of the 6 localities, and especially in Barrow. Indeed, if Barrow's admissions were at the same level as the national average, which in itself is by no means the best practice level, 1,600 less people would have been admitted to hospital.

No one wants to go to hospital unless they really have to. Unnecessary admissions can be extremely stressful for the patient and their family or carers. In a rural county it can mean difficult journeys for family visits. It can also result in delays in treatment, or even treatment that should have been avoided if the condition worsens as a result of the delay.

There is also a very high opportunity cost for these admissions. If the 1,600 admissions in Barrow had been avoided (ie if Barrow's rate was the same as the national average), £2.24m would have been available for re-investment in primary care, such as GPs, community nurses, health visitors and so forth. Much of the time of these additional primary care workers could have been spent on the upfront public health work so vital to improving long term health outcomes.

In other words, changes such as these are vital and I wholeheartedly support them as one of the main ways we can free up the time of the health care "life savers" to walk up the river bank to help prevent people from jumping or being pushed in.

So, what was proposed in Closer to Home and how far has this been implemented? Closer to Home set out a number of key changes. See opposite.

However, it is important that these changes are seen alongside other developments which are taking place to bring care closer to home, such as those in community pharmacies.

It is clear that NHS Cumbria is making good progress, but there is still a long way to go. However, these changes are vital to the future wellbeing of the county and must be continued.

Recommendation 8

I recommend that NHS Cumbria continues to deliver on the Closer to Home agenda, with a strong emphasis on upfront public health initiatives and public engagement and self management.

Closer to home implementation progress

Proposal	Progress to date
Greater engagement of clinicians in leading and shaping change through the development of 6 locality commissioning boards, each chaired by a lead GP.	All six localities (Allerdale, Furness, Carlisle, Copeland, Eden and South Lakeland) have established locality commissioning boards which are GP-led.
New arrangements for emergency care, including a Single Point of Access (SPA); a new Primary Care Assessment Service (PCAS) in Carlisle, Penrith, Kendal, Barrow and Whitehaven; and a new Emergency Treatment Centre at Carlisle Infirmary.	Proposals for an SPA are still being developed, with an anticipated start date of later in 2009. PCASs have been established in Carlisle, Penrith, Kendal, Barrow and Whitehaven. Accident and Emergency Services have been transferred to Carlisle from Whitehaven and the new Emergency Treatment service is being shaped.
A new lease of life for our community hospitals – including the provision of step up and step down care beds ('step-up', where a patient can receive a higher level of observation or support than is possible at home; or 'step down', which enables patients to be discharged from an acute hospital in order to continue to be treated more locally before they return home).	Outline proposals for modernising community hospitals were approved by the North West Strategic Health Authority in 2008. Detailed plans for each individual hospital are now being developed, with Cockermouth being the first to reach the design stage.
Extra primary care such as integrated health and social care services to support care for people in their homes.	GP-led step up and step down care beds are available in all the nine community hospitals and in Kendal, Barrow, Carlisle and Whitehaven. Integrated health and social care teams are being established in all six localities.
Changes to the acute hospitals at Carlisle and Whitehaven.	As agreed following consultation, two hospitals are being maintained in Carlisle and Whitehaven. Plans are being developed for a £100m new hospital replacement for the West Cumberland Hospital in Whitehaven. North Cumbria University Hospitals NHS Trust is developing implementation plans to re-shape the number of beds in line with the reduced needs, as more care is being provided in primary and community settings.

Case study 6

Community pharmacies contribution to public health

In January 2008, community pharmacies in North Cumbria provided for the first time an emergency contraception ('morning after pill') service.

This free, confidential and easily accessible service (no appointment required) has been provided by South Cumbria pharmacies since 2001, where we have seen the gradual shift of this service from general practice to community pharmacies. Most recent figures show that 72% of all supply of the 'morning after pill' is by community pharmacists. This service is now provided by 80 of the 102 pharmacies across Cumbria, resulting in nearly every town having a pharmacy with this service.

Audit data revealed that many women requested emergency contraception after unprotected sex. The pharmacists are trained to counsel the women on the risks of sexually transmitted diseases. However, since January 2009 the pharmacists are also offering free Chlamydia testing kits to women under 25.

Since January 2009, community pharmacies have been contributing to supporting people to become smoke free. Participating pharmacies across the county are offering free advice and regular support, including nicotine replacement. Sixty pharmacies have signed-up to the scheme, which will give greater access to NHS stop smoking services. Over 100 pharmacy staff have been trained to deliver the new service. Would-be quitters can make an appointment or just pop in to any pharmacy displaying the special 'Become Smoke Free' sign.

They can get up to seven support sessions at their chosen pharmacy and nicotine replacement therapy for up to 12 weeks. This service is free for people who do not pay for their prescriptions

Section 5:

A health system based on good intelligence

In this section I underline the need for good intelligence if we are to have an evidence based system for identifying improvements, establishing options and making decision on better health care and health outcomes.

One of the challenges facing the health service is to make sense of the enormous volume of information that is collected within the NHS.

If we are serious about commissioning services that improve the health of people in Cumbria, we need to turn our information into intelligence that enables us to make the best decisions. Good health intelligence uses the most up to date information to target the causes of ill health, identifies interventions that are known to work and measures the outcomes so that we can monitor our progress.

For the Health Service, there have always been two principle weaknesses in the way we collect data. Firstly, we measure health in terms of the number of deaths from a given condition, understandable perhaps when death is so straight forward to measure. Secondly, there is a preoccupation with process measures of clinical activity, such as waiting lists and waiting times for hospital treatment, which distracts attention from measuring health itself.

The British system of vital statistics based on the recording of birth and death, supplemented by hospital activity measures and some social surveys, is no longer adequate if we are to get upstream of threats to health.

The introduction of the new GP contract brought with it practice-based data on specific disease areas such as heart disease. Contained within these is information on smoking, obesity, cholesterol and blood pressure; important factors on the health agenda and essential to good public health.

The data being generated from general practice under the Quality Outcome Framework (QOF) is being used as the basis of a proper epidemiological intelligence system for planning a Closer to Home model of healthcare services, based on public health considerations.

A lot has happened since my last annual report. Our public health strategy identified the development of our intelligence systems as a key priority.

Cumbria Intelligence Observatory was officially launched in December 2008. It is providing comprehensive integrated intelligence on health and wellbeing in Cumbria and its districts. It is a partnership initiative between Cumbria County Council and the NHS in the county, Police, Fire and Rescue Service, Cumbria Vision, the University of Cumbria and other members of the Cumbria Strategic Partnership.

Our observatory has already produced a number of joint intelligence documents including area profiles and joint strategic needs assessments. Cumbria Intelligence Observatory has a Strategic Board that reports to Cumbria Strategic Partnership and has its own logo and its own website.

Complementing the work of the observatory, NHS Cumbria has commissioned a series of life cycle reports on the county from the North West Public Health Observatory. The first of these, Born in Cumbria, is nearing completion.

The development of the Joint Strategic Needs Assessment (JSNA) programme in Cumbria is taking place in several stages. A web based information resource has already gone live

The seven information sources

1. **The people of Cumbria:** This includes information on the numbers of people living and working in Cumbria and how this may change in the future.
2. **Health and wellbeing status:** This comprises of measures of the health and wellbeing of people living in Cumbria.
3. **Determinants of health and wellbeing:** This is where we capture information on factors that affect the health and wellbeing of people in Cumbria, such as poverty or smoking for example.
4. **Services:** This is where we provide information about the services people are using, how accessible these services are and their quality.
5. **What works:** This is where we capture information from research and examples of effective practice, showing what we know about what works to improve health and wellbeing
6. **Voice:** This is where we capture the views and experiences of people in Cumbria. Local people let us have their views through a wide range of mechanisms including consultations, special engagement exercises and complaints. This tells us about people's priorities, what they think would improve their health and wellbeing and their experience of care services.
7. **Action:** JSNA is not just about data; it is about changing the lives of residents and is therefore an ongoing process.

and a number of needs assessment and public engagement projects, focused on specific communities and issues, are ongoing.

The Joint Strategic Needs Assessment (JSNA) model in Cumbria is based on bringing together seven sources of information, relating to the needs of people living in Cumbria, and using these to influence how services are provided. See above.

Good public health intelligence is at the forefront of improving health. It will be essential for identifying the determinants of health inequalities in Cumbria.
Side by side in Cumbria, we have some of the wealthiest people in the country and some of the poorest. The social geography is stark. By assessing population need and using equity audits, services can be targeted so that they serve those who need them most.

Monitoring the use of services according to socio-economic groups will facilitate this. We have made a good start, but there is still more to do. Over the next year we will be increasing our capacity to undertake health economics appraisals and developing programme budgeting, as one of the tools that will help us prioritise our new investments. We will also be looking more closely at our localities and comparing the health of people living there.

Recommendation 9

I recommend that a suite of registers be established focusing on health issues such as low birth weight babies, children with disabilities and dementia. The registers will help us to target our services more effectively and improve wider partnership planning

Section 6:

Building capacity

In this section I look at how we are currently using all of the resources we have in Cumbria, not just NHS, but all public, private and third sector, to improve health and wellbeing.

Health improvement is achieved by the actions of a wide range of organisations and players outside, as well as within, the NHS. Partnership working is central to the development of a workforce and a population with the skills and knowledge both to support improvement in the health of others and to improve their own health.

Partnership work in Cumbria is focussed around the Local Area Agreement (LAA). This is the mechanism through which central government agrees with an area (such as a county) the priority issues for improvement and the targets that should be achieved.

In 2008-09, Cumbria moved from our “First LAA” to the new “Cumbria Agreement”, where we agreed to work together on the 35 priorities we had identified (out of a range of almost 200 government targets) as important priorities for the county. The detail of the Cumbria Agreement can be found on the Cumbria Strategic Partnership website at http://www.cumbriastrategicpartnership.org.uk

Action on the priorities in the Local Area Agreement is delivered through Thematic Partnerships accountable to the Cumbria Strategic Partnership. Each Thematic Partnership develops and oversees action plans to deliver on the agreed targets. Thematic Partnerships for the Cumbria LAA are:

- Children and Young People
- Economic Development and Enterprise
- Safer and Stronger Communities
- Liveability
- Healthier Communities and Older People

District council level Local Strategic Partnerships link into the LAA through the Thematic Partnerships, having their own health task groups at district level. Barrow, Eden and South Lakeland each have a task group, as does West Cumbria. Carlisle is developing its health improvement partnership work through its bid to become a WHO-designated Healthy City.

A central part of the Healthy City approach is the ability of partnerships to engage communities in raising aspirations for good health. See case study 7.

Case study 7:

Carlisle – a Healthy City

Carlisle, as a Spearhead Local Authority, has clearly identified health issues. In adopting the Healthy Cities model, there is an opportunity and willingness to tackle the fundamental determinants of health at local policy level. A healthy city is designed, built and maintained to provide the best quality of life, health and wellbeing for all its citizens.

In putting Carlisle forward for designation as a Healthy City in the fifth phase of the WHO programme, the City Council and its partners acknowledge that health improvements are of concern to all. It is everybody's business. It is a challenge and an opportunity for everyone who lives and works in Carlisle and district.

The city has the advantage of well established partnerships with representation of stakeholders across the sectors. However, achieving Healthy City status will require a sustained level of commitment from all sectors and, in particular, the assurance of continued support at the highest level from local government.

The programme is about political commitment, institutional change, capacity building and partnerships based on planning and innovation. Carlisle's economic success as a city depends on the health of all its residents. The environment in which people live, work, rest and play affects their health.

In taking forward the Healthy City programme, Carlisle is giving a commitment to tackling the risk conditions of health and wellbeing:

- Take action on the main health concerns.
- Support healthier lifestyles.
- Target people, places and settings.

Already in place are:

- A strong commitment to health.
- A structure - the Local Strategic Partnership, Carlisle Partnership and the Thematic Tasks groups.
- A process - to work towards health improvement. This year a health profile for the city and a robust health improvement plan for collaborative action have been developed.

Carlisle is now ready to submit an application for designation as a Healthy City to the World Health Organisation Healthy City programme.

2000

Section 6:

The attributes of a healthy city, pioneered by Liverpool City Council, apply equally to Carlisle and indeed the whole county. See figure 13.

In my past experience with the Healthy City initiative, I have seen what a positive force for good this can be. I would like to see the initiative embraced not only in Carlisle but throughout Cumbria, with a network of a healthy towns and communities across the county.

Recommendation 10

I recommend that we establish a network of a healthy city, towns and villages across Cumbria in order to engage stakeholders and residents in improving the health of their communities.

Figure 13: The key attributes of a healthy city

1. The meeting of basic needs (for food, water, shelter, income, safety and work) for all the city's people.
2. A clean, safe natural and built environment of high quality with attractive streetscapes and open spaces that provide access for all.
3. An ecosystem that is stable now and sustainable in the long term, with clean rivers and bathing waters.
4. A cohesive and inclusive city, built to enhance social justice and good citizenship.
5. A high degree of participation and control by the public over decisions affecting their lives, health and wellbeing.
6. Balanced and integrated transport to ensure access to goods and services and to enhance economic competitiveness.
7. Access to a wide variety of cultural experiences and resources, with the opportunity for social contact, interactions and communication.
8. A diverse, vital and innovative city economy providing opportunities for all and where no individual or community is excluded.
9. The encouragement of connectedness with the past and the cultural heritage of the city and a place of continuing renaissance where the schools, colleges, training centres and universities are so good and so relevant that learning is a way of life for all.
10. An optimum level of engagement in public health by individuals, families, communities, the health workforce and all public, private and voluntary sector organisations, resulting in high level health status (high levels of wellbeing and low levels of disease).

Section 6:

Within each thematic partnership, strong links between agencies in the statutory and voluntary sector have enabled new ways of working to tackle some of the challenges which Cumbria faces.

For example, the commitment of the Healthier Communities and Older People Partnership to reducing smoking prevalence in Cumbria is supported by strong relationships with Trading Standards and the Fire and Rescue Service.

Trading Standards use test purchasing to enforce underage sales legislation to stop children from buying tobacco, whilst the Fire and Rescue Service use the opportunities provided by their Fire Safety Home Checks to put people in contact with the Smoking Cessation Service.

We are now looking to develop a reciprocal arrangement, where NHS staff visiting patients' homes take the opportunity to check for smoke alarms and make referrals to Fire and Rescue where needed. Similarly, the initiative "Together We Can" allows public agencies to talk to communities with one voice to understand better and address their needs and challenges.

In both these examples, as we develop our partnerships and share responsibility for health improvement between organisations, we build capacity within each other's organisations. Staff are enabled to provide a wider range of support to clients and to take opportunities which may otherwise be missed to link people to services, which can in turn help them to be healthier. We also create opportunities to improve the health of the staff of those agencies, increasing their knowledge and skills in relation to health.

New partnerships have developed to address specific issues. For example, in April 2008 the Cumbria Alcohol Strategy Group published an alcohol strategy for the county, "Time to Call Time", and now oversees a comprehensive action plan to deliver the aim of reducing alcohol-related harm.

In a similar way, partners have come together to address the challenge of obesity within our population, and in particular amongst our children. The National Child Measurement Programme now provides us with annual data on the height and weight of Cumbrian children in reception year and Year six. This challenges us to support overweight and obese children and their families to work towards a healthy weight. We must also tackle those factors in our environment (so-called obesogenic factors) that make it hard for people to achieve and maintain a healthy weight. See case study 3, page 34.

A Healthy Weight Strategy Group has been brought together to identify priority actions to support Cumbrians to eat a healthier diet and to become more physically active, through promoting access to healthier food and increasing opportunities for an active lifestyle. The actions needed to support change need the concerted effort of many organisations and the strategy will work through existing, strong and established partnerships, such as the Childrens' Trust and the Health and Wellbeing Board, to achieve change.

Through each of these partnerships, many more people become engaged in the task of health improvement. As well as the influence this can have through their contact with clients, we also build their capacity to improve their own health.

The Health and Wellbeing Strategy of Cumbria County Council is an excellent example of an initiative developed through partnership working with the NHS, which aims to encourage all County Council departments to increase their contribution to health improvement, and to support the health improvement of staff themselves. See www.cumbria.gov.uk/healthandwellbeing

We intend to build on this by developing workplace health programmes for a range of Cumbrian employers, large and small, public and private sector.

We are also seeing innovative approaches to partnership working, including the use of website technology such as u-xplore.com, which can interactively support:

- Health education in schools.
- Careers guidance on different roles in health and wellbeing.
- Personalised health account for all 500,000 residents in Cumbria, which will allow them to monitor and manage key health information such as their vital numbers – weight, blood pressure, body mass index and so on.

There are still far too many partnerships and some rationalisation is needed This is particularly the case in the area of regeneration, where a lack of focused activity can make it hard to encourage effective consideration of health alongside wealth issues. However, in my view partnership working in Cumbria is on the whole good and improving.

Section 7:

The arrangements for public health in Cumbria

In this section I set out my vision for how we can mobilise the public assets of Cumbria to improve public health.

For the first time since 1974 with the creation of the post of Director of Public Health and County Medical Officer, Cumbria has public health leadership which is firmly rooted in its local authorities as well as in the National Health Service.

The Cumbria Strategic Partnership (CSP) is the countywide partnership in Cumbria which brings together the public, private and third sector organisations in Cumbria. It is responsible for developing and delivering a Sustainable Community Strategy and implementing the Local Area Agreement. The Health and Wellbeing Board of the CSP co-ordinates strategic partnership arrangements for the delivery of health and social care within Cumbria.

We are now beginning to see an emerging system for protecting and improving health and wellbeing in Cumbria. To date, the key components of this include:

- The Cumbria Intelligence Observatory
- The Joint Strategic Needs Assessment
- The Joint Health Unit
- GPs with special interest in public health
- Strong partnerships at county and district level, such as the Cumbria Strategic Partnership and district Local Strategic Partnerships.

During 2009, the nature of the emerging Local Area Partnerships (LAPs) will become clear at the supra-parish level. This should provide an opportunity for strong front line working between: health visitors; school and community nurses; social workers; environmental health officers; planning officers; teachers; sports development officers; police; pharmacists; librarians etc.

Working with partners, the reinvigoration of the healthcare estate will provide opportunities to include, in mini-health campuses and villages, facilitation for teaching and research with strong links to the university.

By 2010, we expect to be able to report on the arrangements we have in place for a robust health and wellbeing system for Cumbria and one which is fully engaged with Cumbria's 500,000 citizens.

Section 8:

Conclusions and recommendations

This section summarises my overall conclusion and recommendations.

In conclusion, I believe that the health of the people of Cumbria is good and improving, but the overall position masks some alarming disparity. I am confident that the plans which NHS Cumbria and its partners have in place will make significant improvement in health outcomes and reduce health inequalities. However, more still needs to be done to ensure we have the fully engaged scenario that Sir Derek Wanless* talked about. We need to continually help the lifesavers to move up river to help prevent people falling in to bad health.

* Wanless Report: Securing good health for the whole population, 2004.

Summary of recommendations

1. I recommend that the local authorities in Cumbria investigate making greater use of their wellbeing powers and assess the extent to which they could make imaginative local legislation through bylaws to improve health and wellbeing.

2. I recommend that at the next refresh of the Cumbria LAA, the Cumbria Strategic Partnership should ensure that partners build in targets and actions which clearly show, for the key determinants of health inequalities, how we will 'level-up' the outcomes in deprived areas to those of the best in the county. They should also make explicit cross-cutting actions that are needed to make real progress (getting out of silos).

3. I recommend that the housing authorities in Cumbria take urgent steps to ensure that a comprehensive and consistent private sector housing conditions survey is carried out on a regular basis and linked more effectively to strategic planning (eg for "lifetime homes" planning for future needs and an ageing population; transport planning; and for supporting integration of services at supra-parish or local area partnership level).

4. I recommend that NHS Cumbria and the County Council, working through the Cumbria Information Observatory, set up systems to assess whether there is an adverse impact on health among BME groups in Cumbria and, if so, to give positive recommendations on the issues to be addressed.

5. I recommend that the Cumbria Strategic Partnership takes the lead in bringing partners together to pilot innovative approaches to reducing the impact of inequalities on children. A concrete example is organised activities for children and young people in holidays which are entertaining, can build social and other skills and can divert them from possible anti-social behaviour.

6. I would like to see positive approaches to tackling fuel poverty which also give the opportunity for job creation through greater harnessing of renewable energy for heating homes.

7. A capacity building strategy based on mapping community assets should be explored with some urgency by public, private and third sectors, co-ordinated through the Cumbria Strategic Partnership.

8. I recommend that NHS Cumbria continues to deliver on the Closer to Home agenda, with a strong emphasis on upfront public health initiatives and public engagement and self management.

9. I recommend that a suite of registers be established focusing on health issues such as low birth weight babies, children with disabilities and dementia. The registers will help us to target our services more effectively and improve wider partnership planning

10. I recommend that we establish a network of a healthy city, towns and villages across Cumbria in order to engage stakeholders and residents in improving the health of their communities.

The final word

Finally, I am often asked for my top tips for a healthy life.

Ten tips for a healthy life

1. **Don't smoke.**
2. **Eat a balanced diet.**
3. **Be physically active.**
4. **Limit your stress.**
5. **If you drink alcohol, do so in moderation.**
6. **Cover up in the sun.**
7. **Practice safe sex.**
8. **Get a regular check-up, including screening for common diseases.**
9. **Drive carefully, always wear a seatbelt, respect speed limits and don't use a mobile phone whilst driving.**
10. **Learn first Aid and CPR (Cardio Pulmonary Resuscitation)**

Underpinning this menu for healthy life is a recognition that healthy citizens are active citizens, not just physically and mentally but also democratically. Healthy citizens participate fully in family and community life and, as a result, have a degree of control over their health conditions. This can enable them to lead a full, healthy and happy life. This and no less than this must be the goal for Cumbria.

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