

Public Health Report 2013

Those who have served

"Primum non nocere"
(*"Above all, do no harm"*) –
Latin edict.

"Salus Populi Suprema Lex"
(*"The health of the people is
the highest law"*) - Cicero in
The Twelve Tables (450BC) –
the earliest written statement
of Roman law.

"For the general promotion of
the means necessary to
prevent disease, it would be
good economy to appoint a
district medical officer
independent of private
practice, and with the
securities of special
qualifications and
responsibilities to initiate
sanitary measures and reclaim
the execution of the law." –
Edwin Chadwick's report on
sanitary conditions (1842).

"It [social security] is one part
only of an attack upon five
giant evils: upon the physical
want with which it is directly
concerned; upon disease,
which often causes that want
and brings many other
troubles in its train; upon
ignorance, which no
democracy can afford among
its citizens; upon squalor,
which arises mainly through
haphazard distribution of
industry and population; and
upon the idleness which
destroys wealth and corrupts
men, whether they are
welfared or not." - Report of
the Inter-Departmental
Committee on Social
Insurance and Allied Services,
Sir William Beveridge (1942).

"We will stop the top-down
reorganisations of the NHS
that have got in the way of
patient care." Coalition
Government Agreement of
May 2010.

"The NHS will last as long as
there are folk left with the
faith to fight for it." Health
Minister Aneurin Bevan (1948).

"No one could come up with a
scale of change like the one
we are embarking on at the
moment. Someone said to me:
'It is the only change
management system you can
actually see from space – it is
that large'." NHS Chief
Executive Sir David Nicholson
(2010).

"Public health is the science
and art of preventing disease,
prolonging life, and
promoting physical health and
efficiency through organized
community efforts for the
sanitation of the
environment, the control of
community infections, the
education of the individual in
principles of personal hygiene,
the organization of medical
and nursing service for the
early diagnosis and preventive
treatment of disease, and the
development of the social
machinery which will ensure
to every individual in the
community a standard of
living adequate for the
maintenance of health."
American public health leader
C.E.A. Winslow (1920).

_Health in numbers

- Cumbria is England's second largest county, with a population of 499,800.
- There were 5,464 deaths and 5,033 births in 2011.
- There are 74 people per km² of Cumbria. Population density is highest in Barrow at 866 people per km² and lowest in Eden at 25 people per km².
- 43% of people in Cumbria are aged over 50, compared with 34% nationally.
- 249 people were killed or seriously injured on Cumbria's roads in 2011.
- The average house price in Cumbria in 2012 was £143,683, compared with the national average of £172,706.
- The average household income in Cumbria is £25,524, just under £3,000 less than the national average.
- 16% of households in Cumbria have an annual income of less than £10,000.
- 11.3% of Cumbrian people provide some unpaid care, compared with 10.3% nationally.
- In Cumbria 14.1% of people aged 16-64 are claiming benefits, compared with 14.6% nationally.
- Since 2001 the population of Cumbria has risen by 2.5%, compared with a 7.8% rise nationally.
- Life expectancy in Cumbria is 80.2 years, which is slightly lower than the national average of 80.6 years.
- There were 1,623 deaths in Cumbria from all cause cancers in 2011. This gives a rate of 325 deaths per 100,000 people.
- 16% of Cumbrian children live in poverty, which is lower than the national average of 22%.
- 1.5% of Cumbria's population are from black, minority and ethnic groups, compared with 14% in England and Wales.
- 30.9% of Cumbrians aged 16+ eat five or more portions of fruit and vegetables a day, which is higher than nationally at 27.2%.
- 21,900 people have a secondary address in Cumbria.
- 25% of houses in Cumbria are detached, with 32% semi-detached and 30% terraced.
- 4% of households in Cumbria don't have central heating.
- 79% of Cumbrian households have access to a car or van, this is higher than the national average of 74%.



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Foreword_

This is my sixth and final report on public health in Cumbria. These reports have a long tradition beginning in the 1840s with the country's first medical officer of health, William Henry Duncan in Liverpool.

These reports are independently produced by Directors of Public Health and as such cannot be interfered with by other officers or elected members. In a sense they are similar to the reports of the auditor and are intended to be authoritative, evidence-based commentaries. They are not always intended to provide comfortable reading. The protection against dismissal for making uncomfortable comments was established many years ago and is intended to be part of the new settlement as public health moves back into local government on 1st April 2013.

Public health reports have traditionally been presented to local authorities as part of their annual general meeting and are tabled in full council open to the public and media. It is important that this tradition should continue. They are also documents of record for posterity.

Over the past six years I have intended these reports to provide the backdrop for evidence-based discussion, policy and action.

The 2008 report set the scene for the work of the new Primary Care Trust and its partners. It identified Five Challenges, which we will address in greater detail here, and painted a picture of the scope for action and way of working.

The 2009 report explored those challenges in greater detail and reported on the six district localities that make up the administrative and anthropological fabric of Cumbria. It gave examples of work in progress, described the arrangements for public health in Cumbria and made a set of recommendations about building capacity, prioritising actions and developing public health. As with this report, it was accompanied by a pocket book of statistics to ensure that essential data was always at hand.

In 2010 the report majored on mental health using a life cycle approach and emphasised the need to prioritise mental health promotion and services. We now know that when measures other than mortality are used to measure the burden of disease, mental health assumes a leading significance. Concerns about the quality of mental health services were beginning to emerge at this time. A district focus was maintained, progress was reported on the 2009 recommendations and a set of further recommendations was made emerging from the report.

In 2011 the report, which was awarded the prize for the best Director of Public Health Report nationally, was given over to health protection, resilience and emergency planning in the county. Almost from the first day of the Primary Care Trust, Cumbria was thrust into a remarkable series of emergencies and disasters. Beginning with the Grayrigg train crash in February 2007, it was to be followed by serious floods across the county in November 2009, a school bus crash at Keswick in May 2010 where two pupils and an adult driver were killed, the Derrick Bird mass shooting incident on the west coast in June 2010 and a series of clinical service failures necessitating the convening of NHS gold or major incident responses.

I think we can take quiet satisfaction that the NHS and partners have acquitted ourselves well throughout these challenging events. I am pleased that the multi-agency resilience plan in Cumbriaⁱ is now in the public domain on the internet, a major change from the years of cold war secrecy and so obvious in a county such as Cumbria where ordinary citizens were indispensable in many of our recent emergencies.

Over the past six years serious weaknesses have been revealed in a number of clinical services. At the time of writing, it is clear that Cumbria faces a significant challenge if local people are to have access to the quality of care which they have the right to expect.

In 2012 the public health report focussed on the four areas of: childhood epilepsy; working age adults and the impact of the economic recession; older adults with sensory loss; and the health of military veterans.

In this my final report, written in spring 2013, I have taken the theme of 'Those who have served' to focus on whether we are fulfilling our obligations to the remarkable generation who grew up in the 1930s, protected us against the threat of fascism and then invested their time, effort and taxes in building a welfare state to create a better future and tackle the root causes of conflict and war. This generation is now aged 85 and over, increasingly frail and deserving of our honour and commitment.

We will also be examining how NHS Cumbria has served the people of Cumbria in its six-year existence. Have we achieved what we set out to do? Have we met the challenges laid out at the beginning? Is Cumbria a healthier place now?



Professor John R. Ashton

C.B.E. Director of Public Health and
County Medical Officer for Cumbria
2006 – 2013.

Introduction_

As we reach the dying days of the Cumbria Primary Care Trust, it is time to reflect on the ambitions we set out with in the autumn of 2006, the journey we have travelled, and the prospects for those who must now take up the baton.

At the time of the last NHS reorganisation, health care in Cumbria was in disarray. Financial issues dominated the agenda and the people of Cumbria were on the streets fighting to prevent the closure of their beloved cottage hospitals.

The new Primary Care Trust, taking a whole-county view of the NHS for the first time, committed itself to creating a first-class service which was closer to home and led from the community by clinicians in partnership with the public. Saving and rebuilding the cottage hospitals as integrated health and social care resources was seen as an important symbolic first step in support of that goal.

When I published my first public health annual report I identified Five Challenges which would need to be taken on if we were to realise our ambitions. These were as follows:

- The demographic challenge of a rapidly ageing population, a population that was not just growing older in increasing numbers, but living to a great age and often accumulating multiple problems of frailty and difficulties with daily living.
- The stark inequalities in health and wellbeing between the wealthy and the disadvantaged parts of the county, with unacceptable differences in both life expectancy and long-term conditions.
- The need for a fundamental shift and realignment of health and social care away from hospitals and institutions towards independent living with ready access to high-quality health and social care at home and in the community. There was a need for a partnership between professionals and public, with a new social contract of responsibilities and full engagement of all agencies.
- To create a system based on good intelligence that would enable plans and services to be based on evidence rather than opinion or precedent.
- The building of capacity and capability at an individual, family, neighbourhood and institutional level.



When I look back now over the past six years, I believe we have cause for some satisfaction in relation to each of these challenges, but in tackling them other more vexed questions have come to the fore – not least weaknesses in clinical and managerial leadership across various parts of the system and of the county. Revealing such weaknesses is not popular among those exposed, but as shown so clearly recently in mid-Staffordshire, good leadership allied to transparency and reflection is essential if scandals are to be avoided and the pursuit of excellence to be a reality.

The unwelcome, massive top-down reorganisation of the entire National Health Service has once again been an appalling distraction from the central mission of focussing on the health needs of the sick and frail, preventing ill-health and reducing health inequalities.



The Five Challenges – are we meeting them?

Our annual public health reports traditionally make a series of recommendations.

As this is the last report from NHS Cumbria, this year we are taking an overview of the organisation's achievements and examining the big picture of whether we met the Five Challenges laid out at the outset.

Challenge 1_

Demographics

The 2008 public health report described the remarkable transformation in life expectancy in Cumbria in recent times and the discrepancies in different parts of the county.

The leadership shown by Cumbria's general practitioners in assuming control of service commissioning and development points to the way ahead in maintaining independent living and avoiding unnecessary hospitalisation. However, in these times of austerity there can be no let up. Six years on, the pressures on services are unrelenting, and the need for shared ownership of the Closer to Home agenda is, if anything, more urgent now than it was in 2006.

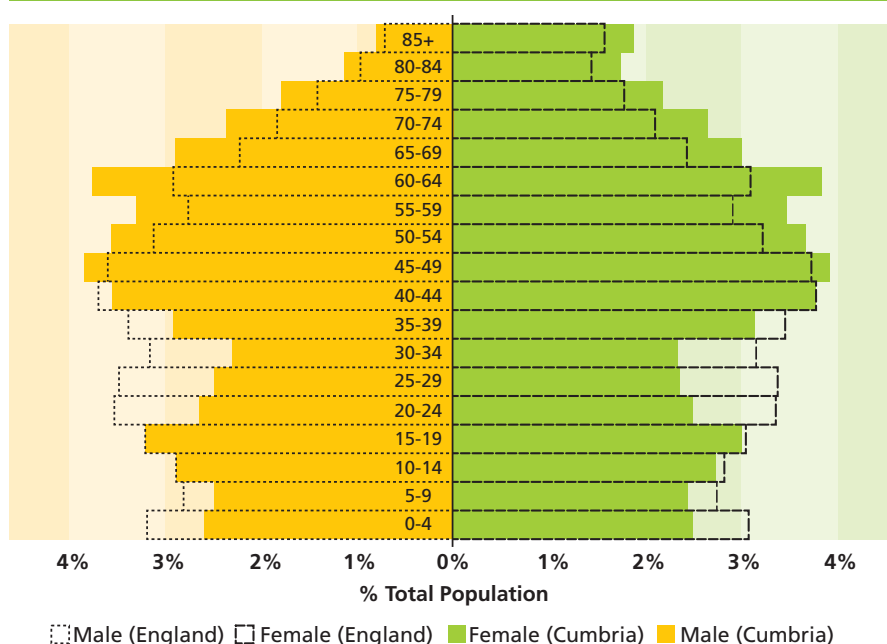
We have to ensure optimal care during the last weeks and months of someone's life. Enabling those who wish to spend their last days at home in the bosom of their family is a clear goal, but one which is still hindered by the taboo of talking about death and a blockage which prevents the dying, their families and medical advisers from moving on from efforts to save life to managing a good death.

We have been fortunate to have the input of Mary Matthiesen in running many workshops at professional and community level. 'Conversations for Life'ⁱⁱⁱ has begun to set a new agenda for end of life in Cumbria, breaking the taboo of silence and enabling people to express their wishes for their final days to those best able to help them experience what they wish for.

The demographic evidence base:

Cumbria has an older population than the national average, with approximately 19,941 more people aged over 65 than would be expected given the England age profile. The number of younger people in the county is also lower than expected, see Figure 1.

Figure 1 : Cumbria and England mid-2010 population estimates



Source: Office for National Statistics / Cumbria Joint Strategic Needs Assessment 2012 to 2015

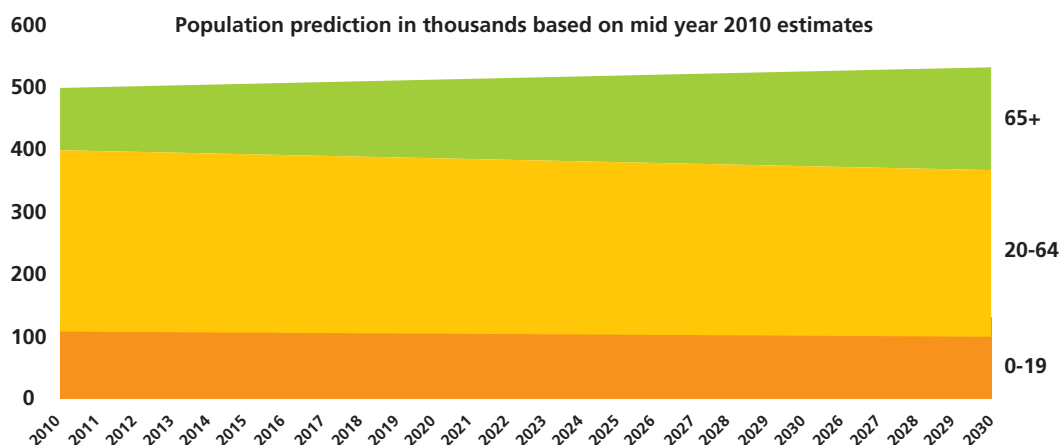
Cumbria's population is ageing rapidly, particularly in rural areas. Since 2001, the number of residents aged over 65 has increased by 13.2%, compared with a 9.8% rise nationally. In addition the number of young people aged under 16 has declined in the county over the same time period by 8.8%, compared with a much more modest decline of 1.4% in England.

There are indications, however, that the number of births in the county has begun to increase in recent years. There are now 1,000 more 0-4 year old children in the county than there were in 2003, with a large part of this increase occurring in Carlisle.

The most recent population projections show that, by 2035, Cumbria's population will have grown by 5.7% to 526,000 (see Figure 2). This increase is largely a result of people retiring into the county, and people living longer.

The population increase is not expected to be evenly spread throughout the county. An 8.1% increase is expected in Carlisle, and only a 2.5% increase in Barrow. This growth is also not expected to be spread evenly across age groups. While the number of residents aged over 65 is projected to increase by 60.5% to 163,000, the number of residents aged 0-15 years is projected to fall by -6.4%.

Figure 2 : Percentage change in the Cumbria population by age group: 2012-2033



Source: ONS / Cumbria Joint Strategic Needs Assessment 2012 to 2015

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

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 estimated:

- 82% increase in dementia.
- 60% increase in hospital admissions for stroke.

This would translate into a 25% increase in the number of people supported for social care needs, equivalent to 198 more nursing home beds (4 new homes); 459 more residential care beds (9 new homes); and 330,000 home care hours if we continue to respond to need by institutional provision rather than supporting people in their own homes.

Challenge 2_

Health inequalities

The fight to redress a lifetime of disadvantage, adversity and risky lifestyles is a tough one. Despite being chronically under resourced for prevention and public health, in Cumbria there is now a much greater understanding of the issues and a real commitment to prioritise the fight for social justice in health.

Our Clinical Commissioning Group is agreed of the need to invest most in those parts of the county where health needs are greatest, as described in the county's Joint Strategic Needs Assessment.

This applies to capital, to personnel and to programmes and projects. An example of what may make a difference has been the screening for lung cancer among long-time smokers in the industrial populations of west Cumbria - early diagnosis leading to extra years of life is a matter of social justice.

With limited resources we have managed to engage extensively through the media and through lifestyle campaigns with the vexed continuing problems of diet, smoking, alcohol, drugs, obesity and exercise.

Unfortunately national economic policies which are out of our control have once again raised the spectre of mass unemployment, especially among young people, with the threat of the legacy of a lost generation similar to the 1980s and its associated burdens of mental health problems, alcohol and drug abuse, and increased suicides. The Cumbria suicide prevention strategy, developed with the energetic contribution of many people and agencies, has hopefully put us in a good place to mitigate the worst prospects that face us.

The health inequalities evidence base

In 2008 one of the main challenges facing the county was the varying life expectancy between different communities in Cumbria and the need to 'level up' so that the worst performing areas (Barrow, Carlisle) matched up with the best (Eden, South Lakes).

Here we will examine how successful the local NHS and partners have been in trying to improve or 'level up' public health outcomes, including the following areas:

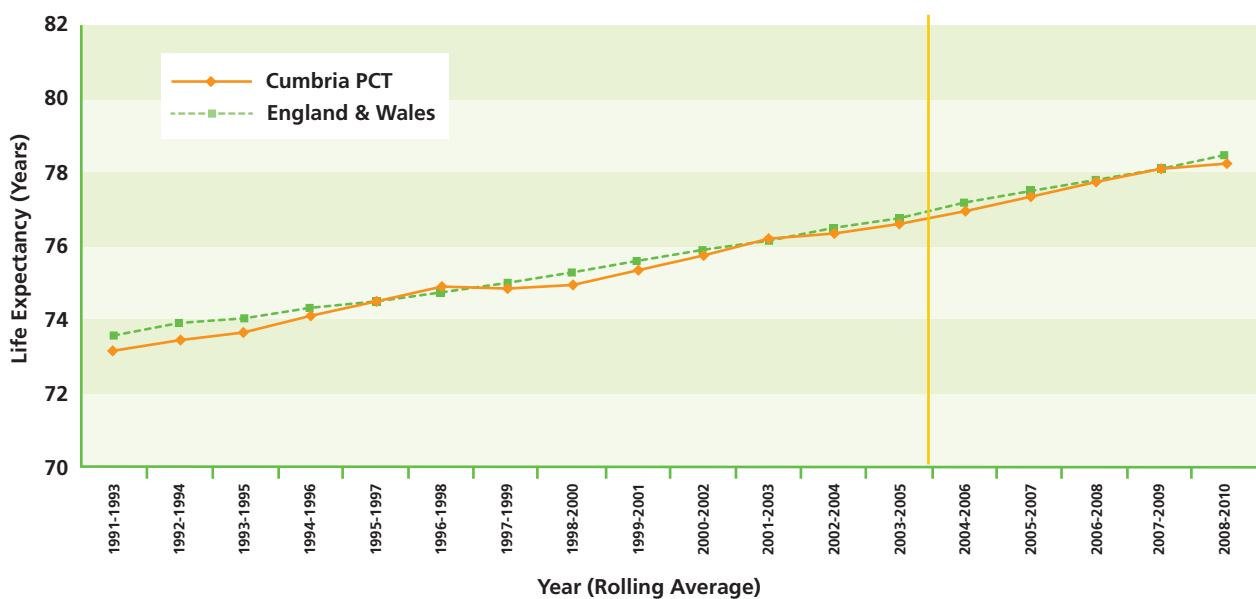
- Life expectancy at birth
- Premature circulatory disease mortality
- Premature cancer mortality
- Infant mortality
- Smoking
- Childhood obesity
- Sexual health
- Mental health and wellbeing

Life expectancy at birth

MALE LIFE EXPECTANCY

In Cumbria, male life expectancy (2008-2010) is slightly lower than that of England & Wales (see figure 3). Life expectancy trends between 2003-2005 and 2008-2010 show that the male life expectancy gap has narrowed in Cumbria by 2.22% (from 76.6 years to 78.3 years) compared with 2.17% in England and Wales (from 76.8 years to 78.47 years).

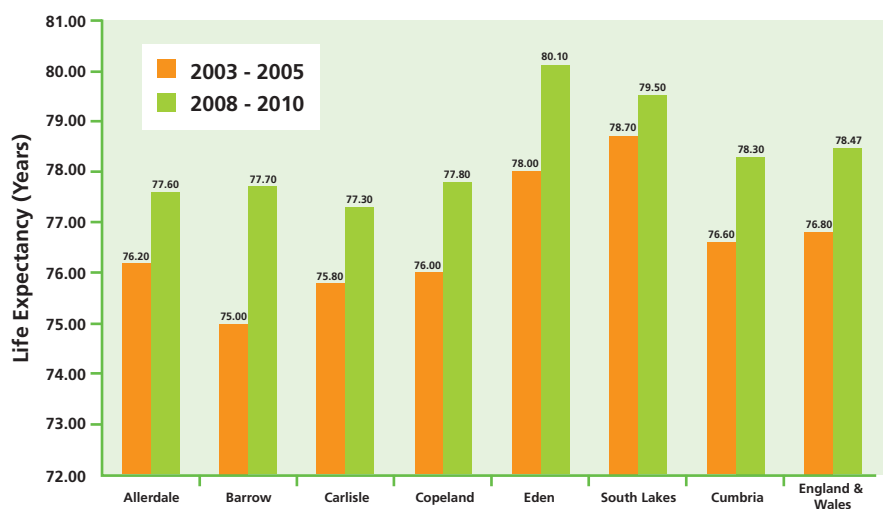
Figure 3: Male life expectancy trends Cumbria vs National 1991-2010



Source: Office for National Statistics

Figure 4: Male life expectancy by district

At district level (see figure 4), life expectancy varies by 2.8 years: 78.7 years in South Lakeland compared with 75 years in Barrow. However, the gap between the best and worst district of Cumbria has narrowed from 3.7 years in 2003-05 to 2.8 years in 2008-10. The gap has narrowed most in Barrow, Copeland and Eden.



Source: Office for National Statistics

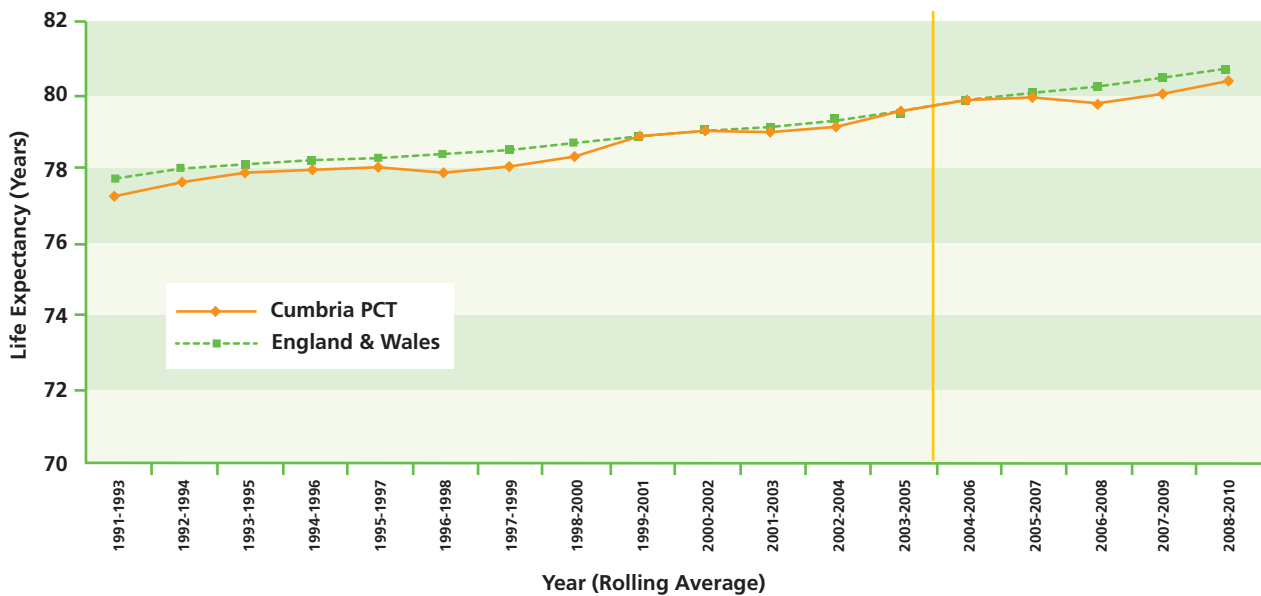
Section 1_

Challenge 2_Health inequalities

■ FEMALE LIFE EXPECTANCY

In Cumbria, female life expectancy (2008 to 2010) is slightly lower than that of England & Wales and the gap between Cumbria and the national average has widened in the last five years (see figure 5).

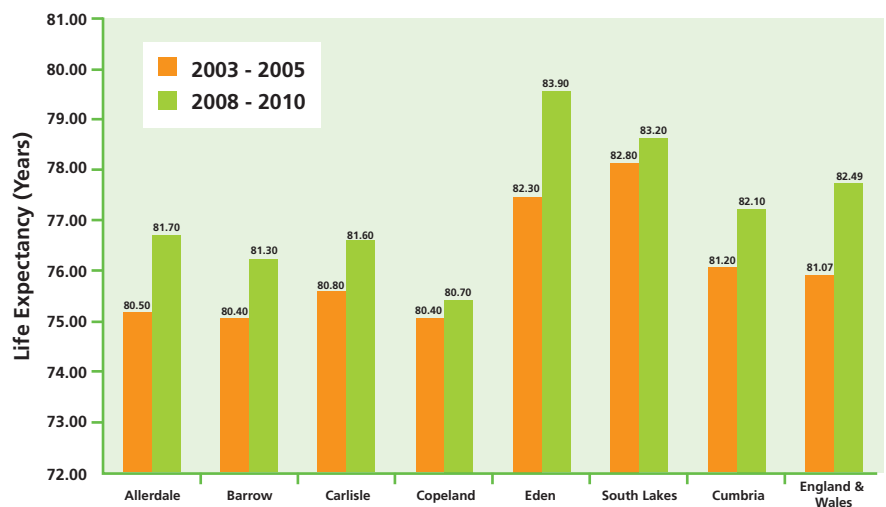
Figure 5: Female life expectancy trends Cumbria vs National 1991-2010



Source: Office for National Statistics

Figure 6: Female life expectancy by district

At district level (see figure 6), life expectancy varies by 3.2 years: 83.9 years in Eden compared with 80.7 years in Copeland. However, the gap between the best and worst districts of Cumbria has widened from 2.4 years in 2003-2005 to 3.2 years in 2008-2010. The gap has widened most in Copeland, South Lakes and Carlisle.



Source: Office for National Statistics

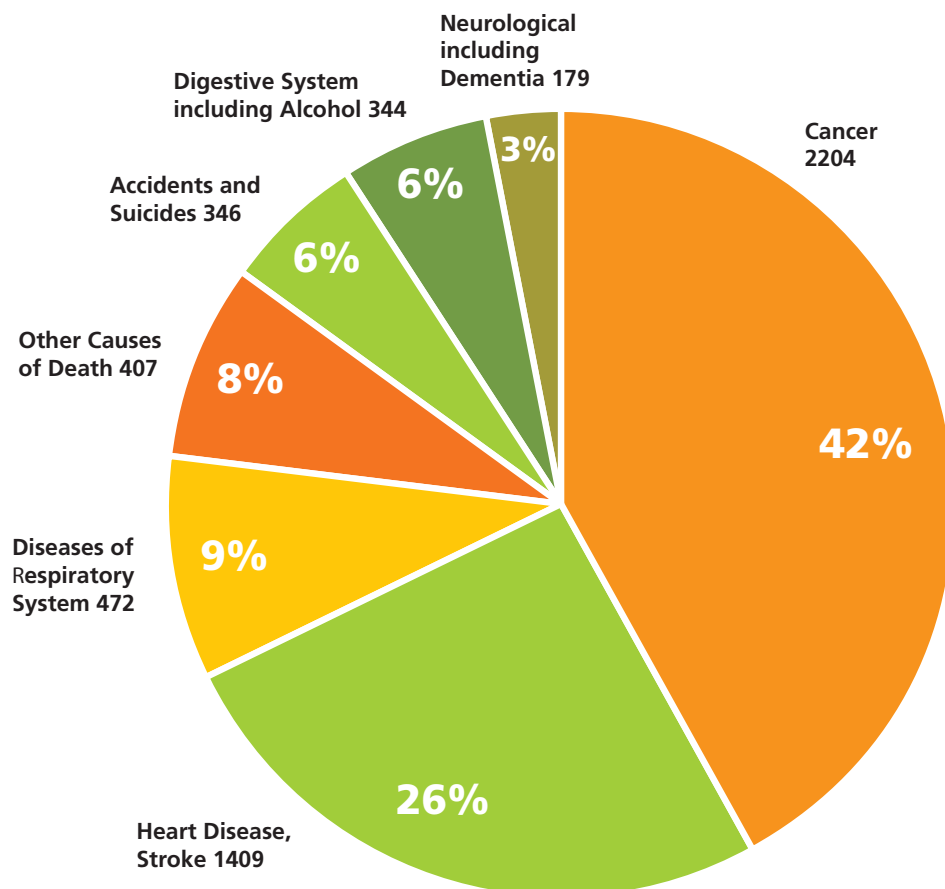
■ PREMATURE MORTALITY

Premature mortality, or dying before your 75th birthday, is a good measure of health inequality. There has been a drastic improvement across Cumbria in the last 25 years, with the chances of men surviving to the age of 75 increasing by nearly a half from 47% to 67% and from 66% to 78% in women.

Fewer than a third of deaths now occur before the age of 75. The three big killers in Cumbria are: cancer; circulatory conditions such as heart disease and stroke; and respiratory diseases such as pneumonia and chronic obstructive pulmonary disease (COPD).

Figure 7 shows the number and main causes of early deaths in men and women. Heart disease is the leading cause of avoidable death. Deaths among men under 65 from heart disease are far higher than among women.

Figure 7: Main causes of premature death for Cumbria – 2008 to 2010



Source: NHS Cumbria Public Health Mortality file / Cumbria JSNA

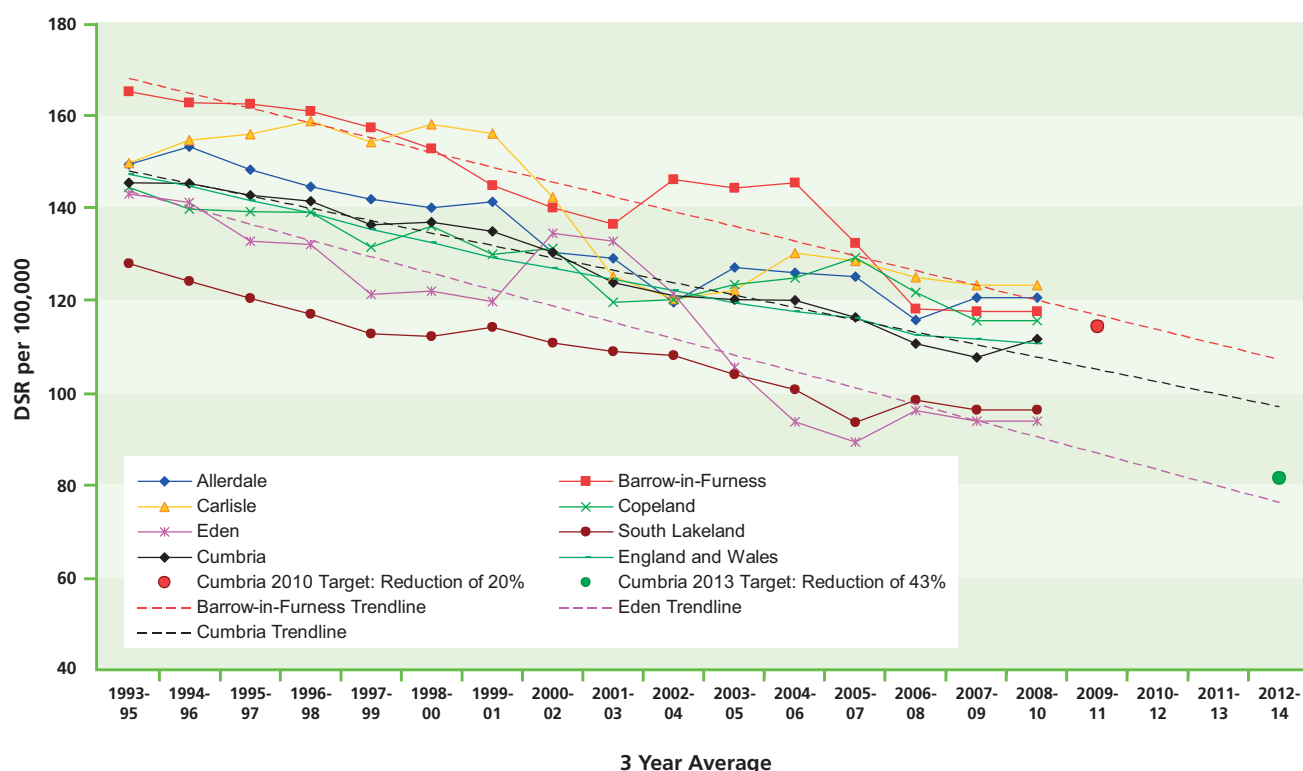
Section 1_

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■ PREMATURE MORTALITY: CANCER

In Cumbria, premature mortality rates from cancer are nearly 111.44 per 100,000 of the population, slightly higher than the national average of 110.48 (2008-2010). The gap between Cumbria and England & Wales has narrowed between 2004-2006 and 2008-2010 – by 7% in Cumbria compared with 6% in England & Wales.

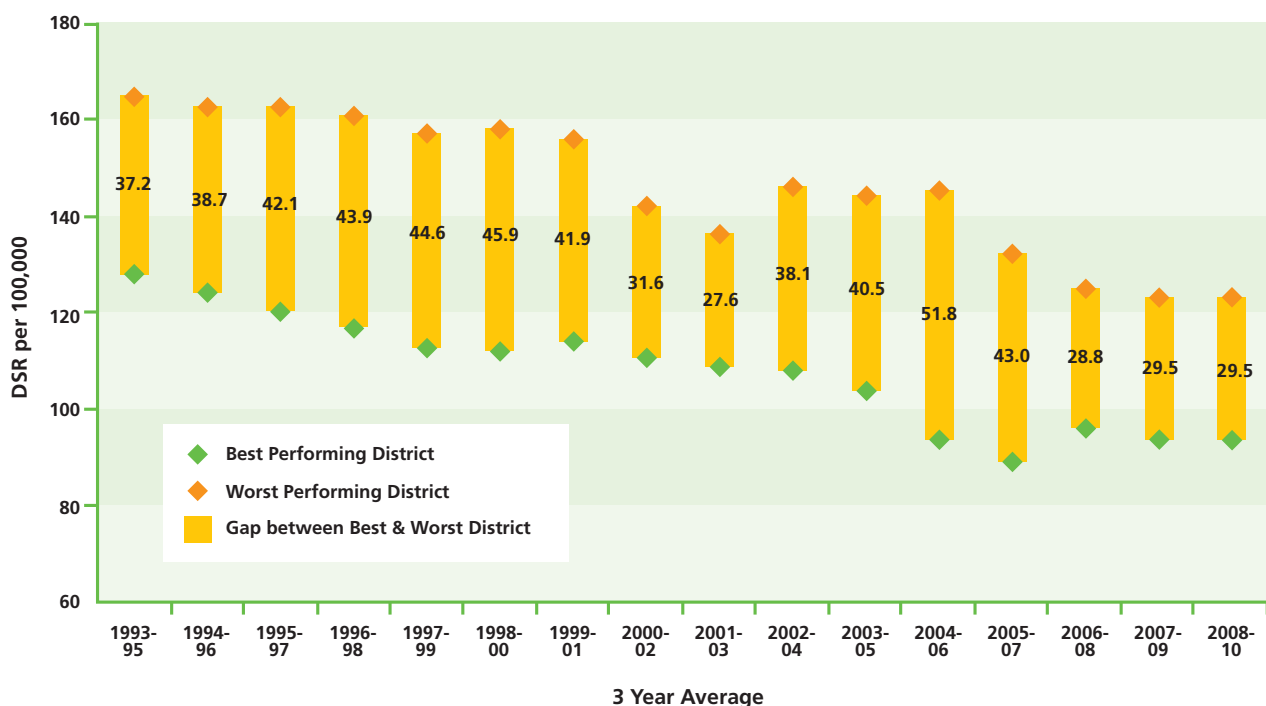
Figure 8: Premature deaths from cancer 1993-2010



Source: Office for National Statistics

Figure 9 shows that the gap between the worst and best performing districts of Cumbria has narrowed between 2004 – 06 and 2008 – 10. The worst performing district in 2004 – 06 (Barrow) has seen a 19.2% decrease in the premature cancer mortality rate to 2008 -10, whereas the best performing district (Eden) has experienced no decrease in the DSR rate per 100,000.

Figure 9: Premature deaths from cancer – gap between best and worst performing Cumbrian districts



Source: Office for National Statistics

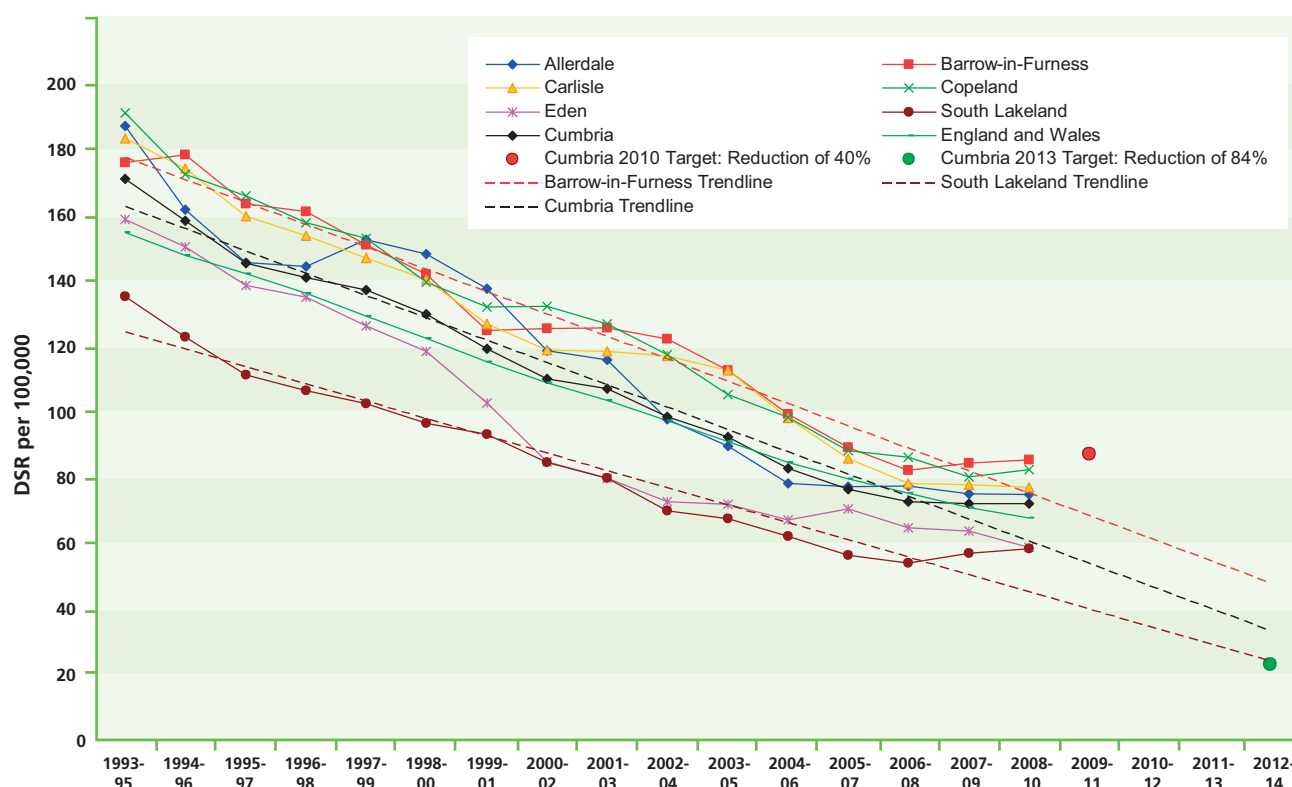
Section 1_

Challenge 2_Health inequalities

■ PREMATURE MORTALITY: CIRCULATORY DISEASE

In Cumbria, premature mortality rates from circulatory disease are nearly 72.25 per 100,000 of the population, higher than the national average of 67.78 (2008-2010). The gap between Cumbria and England & Wales has narrowed between 2005-2007 and 2008-2010 – by 12.9% in Cumbria compared to 20.1% in England & Wales as shown in figure 10.

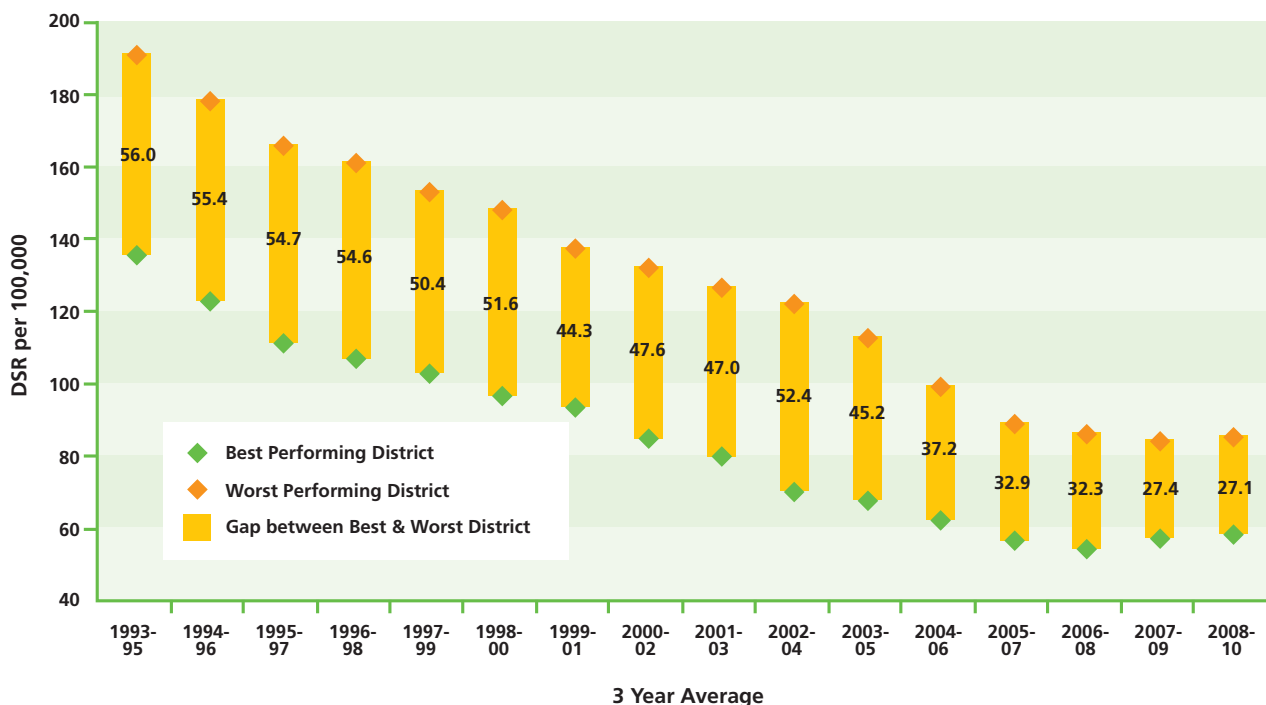
Figure 10: Premature deaths from circulatory disease 1993-2010



Source: Office for National Statistics

Figure 11 shows that the gap between the worst and best performing districts of Cumbria has narrowed between 2005-2007 and 2008-2010. The worst performing district in 2004-2006 (Barrow) has seen a 13.9% decrease in the premature circulatory disease mortality rate to 2008-2010, whereas the best performing district (Eden) has experienced a decrease of 12.3% in the rate per 100,000. The other spearheadⁱⁱⁱ area in Cumbria (Carlisle) has experienced a 21.4% decrease in circulatory disease premature death rates.

Figure 11: Premature deaths from circulatory disease – gap between best and worst performing Cumbrian districts



Source: Office for National Statistics

Section 1_

Challenge 2_Health inequalities

■ INFANT MORTALITY

Research shows that certain risk factors - such as smoking in pregnancy, giving birth to low birth weight babies and not breastfeeding babies during the first few months of life - mean an increased risk of infant death. NHS Cumbria has monitored these three factors closely over the last six years in the effort to reduce mortality in early years and improve life expectancy overall.

Figure 12: Infant mortality trends Cumbria vs National 1997-2011

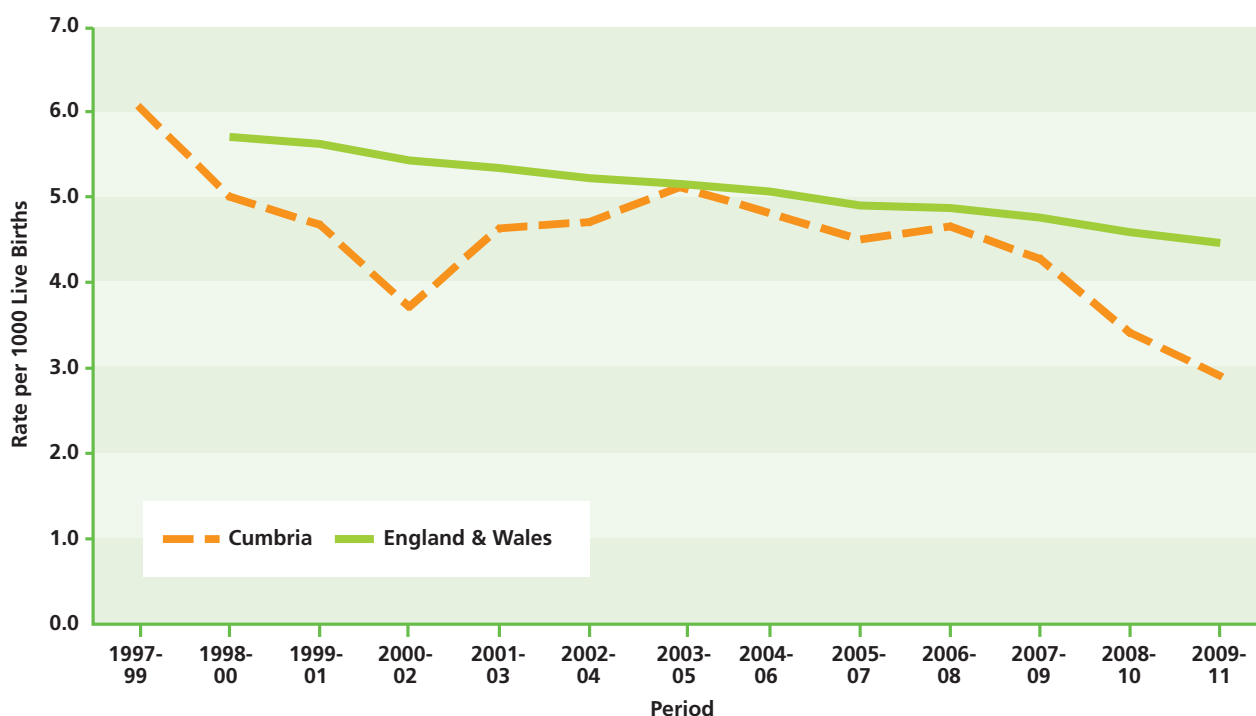


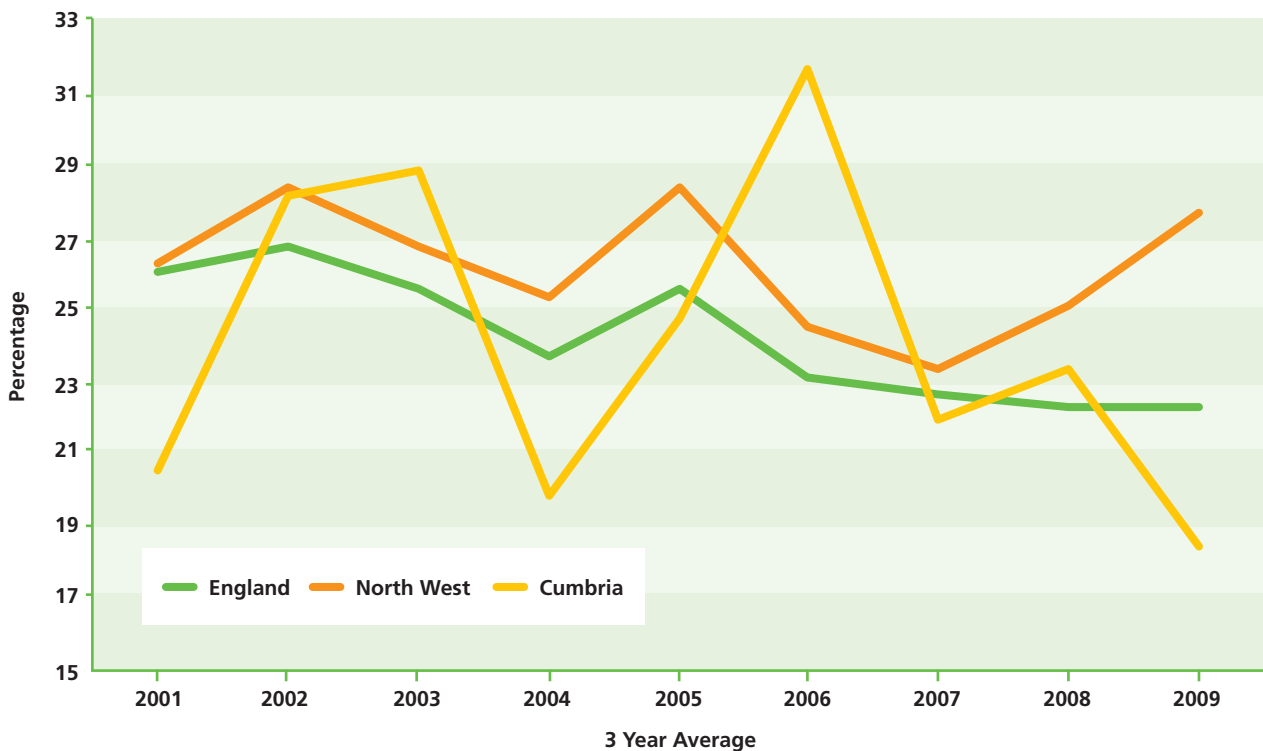
Figure 12 shows the infant mortality rate per 1,000 live births in Cumbria compared with England & Wales, with a clear decrease in Cumbria during the last four periods. The number of infant deaths has fallen from about 23 per year in 2006-2008 to about 15 per year in 2009-2011. The numbers of infant deaths in each district is very low historically.

Source: Office for National Statistics

SMOKING

The main target was to reduce adult smoking rates from 26% in 2002 to under 21% by the year 2010. It is difficult to gauge how many people smoke. The General Household Survey shows the proportion of people smoking in Cumbria has fallen to 18% of the population. Another way of measuring smoking is to look at the smoking cessation service. During the last five years just over 26,000 smokers set a quit date. Of these 15,200 (58%) were successful in stopping smoking.

Figure 13: Percentage of over 16 year olds who smoke – Cumbria vs Regional & National



Source: Office for National Statistics

Section 1_

Challenge 2_Health inequalities

■ CHILD OBESITY

Another key target was to tackle the underlying causes of ill health and health inequalities by halting the year-on-year rise in child obesity. This was a challenging target. A child is measured and weighed in their first year at school and when they progress onto secondary school.

Figure 14: Prevalence of obese children by district, with national averages

		2007/08	2008/09	2009/10	2010/11	2011/12	Difference 2007/08 - 2011/12
Reception Year	Cumbria	9.5%	9.2%	9.6%	9.7%	10.1%	0.7%
	Allerdale	9.7%	6.4%	8.0%	10.2%	9.9%	0.2%
	Barrow-in-Furness	10.4%	14.2%	12.5%	10.8%	12.3%	2.0%
	Carlisle	6.4%	8.2%	9.6%	9.5%	9.5%	3.1%
	Copeland	10.3%	11.9%	10.9%	10.7%	10.4%	0.1%
	Eden	10.5%	7.6%	8.0%	8.3%	10.4%	-0.2%
	South Lakeland	9.8%	7.3%	8.5%	8.4%	8.8%	-1.0%
	England	9.6%	9.6%	9.8%	9.4%	9.5%	-0.1%
Year 6	Cumbria	20.2%	19.7%	18.8%	20.9%	20.3%	0.1%
	Allerdale	20.7%	20.0%	20.7%	21.6%	21.6%	1.0%
	Barrow-in-Furness	23.9%	21.2%	19.2%	20.7%	23.8%	-0.1%
	Carlisle	18.9%	21.0%	18.7%	20.4%	18.6%	-0.2%
	Copeland	22.9%	19.6%	19.6%	24.1%	24.7%	1.8%
	Eden	18.3%	19.2%	19.3%	23.3%	20.4%	2.1%
	South Lakeland	17.4%	16.8%	15.8%	17.1%	14.8%	-2.6%
	England	18.3%	18.3%	18.7%	19.0%	19.2%	0.9%

Source: NHS Cumbria / National Childhood Measurement Program

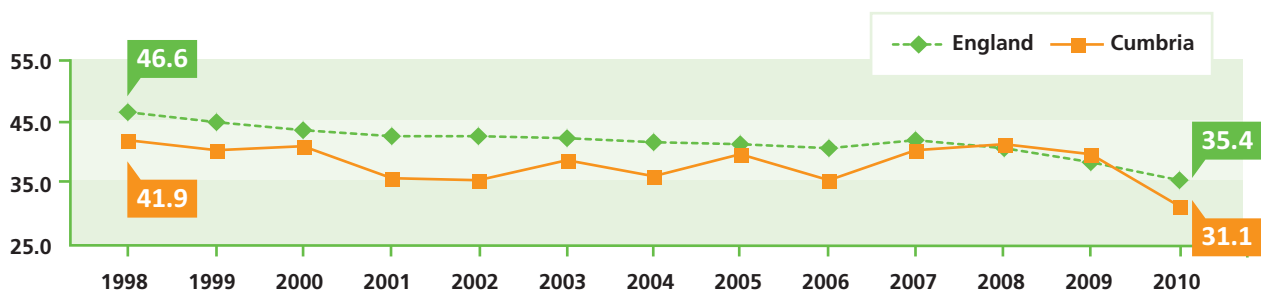
On a county level there has been an increase of just under 1% in the number of children classified as obese when they start school. Carlisle and Barrow record the highest increase in the number of younger obese children. Obesity levels have fallen in South Lakeland and Eden.

There has been a smaller increase (0.1%) in the number of older obese children countywide. This is below the national average increase of 0.9%. Increased levels of obesity are found in the districts of Allerdale, Copeland and Eden. South Lakeland reports a decrease of 2.6% in the number of obese pupils in Year 6.

SEXUAL HEALTH

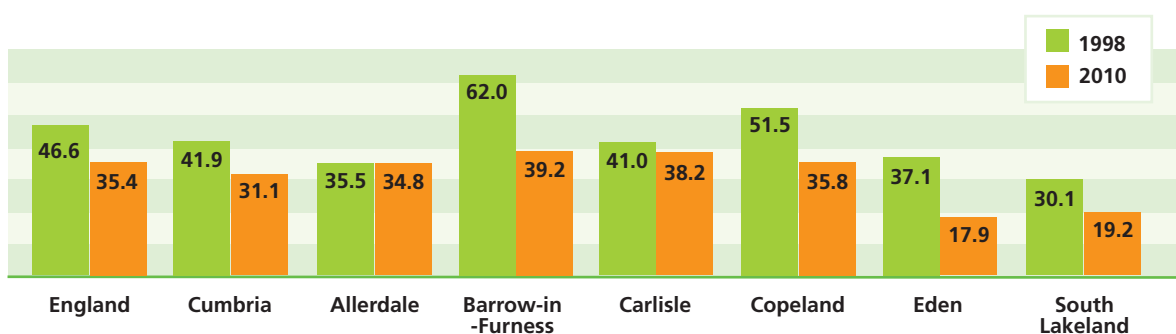
The national teenage pregnancy strategy aimed to halve the under-18 conception rate by 2010. The target in Cumbria was a conception rate of 21 conceptions per 1,000 young women aged 15 to 17 years. This target was not met, nor was it nationally.

Figure 15: Pregnancies per 1,000 girls aged 15-17 Cumbria vs England



Source: ONS DfE

Figure 16: Pregnancies per 1,000 girls aged 15-17 by district



Source: ONS DfE

Section 1_

Challenge 2_Health inequalities

Currently in Cumbria the under-18 conception rate is 31.1 per 1,000. This equates to 281 conceptions. This is the lowest recorded figure. There were 81 fewer conceptions in 2010 compared with 1998. Of the six districts in Cumbria, Eden experienced the greatest reduction (52%) and Allerdale the lowest (2%). This progress is to be welcomed, even though the national target was not met.

Chlamydia screening has been another focus of sexual health. Chlamydia is the most common bacterial sexually transmitted infection, with sexually active young people at highest risk. As chlamydia often has no symptoms and can have serious health consequences (including pelvic inflammatory disease, ectopic pregnancy and tubal factor infertility) opportunistic screening remains an essential element of good quality sexual health services for young adults.

The National Chlamydia Screening Programme (NCSP) in England was established in 2003. Originally this was set up as a blanket screening programme targeting all young people. Now it is more focussed, targeting the sexually active. Current recommendations are that the programme should aim for a diagnostic rate of 2,400 per 100,000. The 2011/12 diagnostic rate in Cumbria is 2,036 per 100,000.

Figure 17: Chlamydia screening Cumbria vs National for children aged 15-24 Years

	Total tests	Percentage of population tested	Percentage of young people testing positive	Diagnoses Rate per 100,000
Cumbria	13,977	24.7	8.2	2,036
England		28.5	7.3	2,090

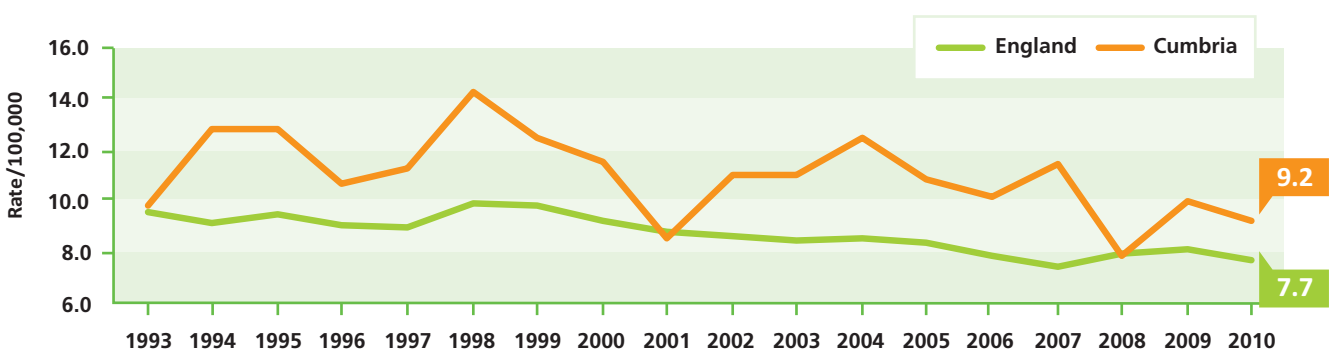


MENTAL HEALTH AND WELLBEING

The Public Service Agreement target was to reduce mortality rates from suicides and undetermined injury by at least 20% no later than 2010 (taken from "Our Healthier Nation baseline targets 1995-97^{iv}). The Cumbria target was a rate of 9.3 deaths per 100,000 people. This target has been met, with a rate of 9.2 deaths per 100,000 people in 2010.

The county now has in place a robust multi-agency suicide prevention strategy based on the hard work done by a dedicated and wide-ranging group. It is hoped that the work of this group will enable the toll from suicide to be reduced in the coming year.

Figure 18: Deaths from suicide and undetermined injury Cumbria vs National



Challenge 3_

Reorientation of health and social care to be Closer to Home

I have already referred to the impressive leadership shown by GPs, other clinicians and their teams in primary care. I am particularly pleased that our GPs have embraced public health with an enthusiasm that I have never met before in such a systematic way. We were helped in our journey of development by the inspiring inputs from public health leaders who came and ran workshops and offered guidance. I would particularly like to place on record my thanks to Leon Epstein from Jerusalem and Lowell Levin from Yale.

A public health orientation to general practice is known internationally as Community Orientated Primary Care. Our GPs have now placed themselves in the forefront of this growing movement.

Hand in glove with Community Orientated Primary Care has been the focus on Total Place, something which had its origins in the county with the work of the Cumbria Strategic Partnership, a predecessor of the Board of Health and Wellbeing. The involvement of Carlisle in the World Health Organisation's Healthy Cities Project has built on the Total Place concept, generated enormous enthusiasm for joined-up policy within Carlisle

at both the city and neighbourhood levels, and cemented the relationship between primary care and the local authority.

The third key factor in transformational change has been the growing movement of Asset Based Community Development. This has its origins in the inner cities of America and the work of John McKnight from Chicago. McKnight and his colleagues have spent 40 years finding ways to map, unlock and mobilise the assets of individuals, associations, neighbourhoods and institutions. They start from the premise that individuals and communities are half full rather than half empty and that, by perpetuating a client status among receivers of public services, we are squandering the resources of people and their ability to be in charge of their own destinies.

The reorientation of professional styles of working to be alongside communities and individuals, supporting them in their ambitions rather than trying to fix them, is an essential part of this work. The rich tradition of community organisation to be found in Cumbria has proved a fertile ground for this approach and we were privileged to have John McKnight visit on two occasions to run training workshops with large numbers of professionals, elected members and community activists.

One of the most remarkable examples of the synergy to be derived from all three approaches of Community Orientated Primary Care, Total Place and Asset Based Community Development took place in Cockermouth in the aftermath of the November 2009 floods, galvanised by local GP Dr John Howarth and the amazing people of that town.

There are many other examples of similar work in towns, villages and communities around the county. I am pleased to report that a new initiative will enable them to join the revived UK network of Healthy Cities with its resource centre at the University of Central Lancashire.

The Closer to Home evidence base

For a number of years, GPs have been involved in planning how and where health services should be delivered for communities. Now GPs are taking on a more formal role. Family doctors will be responsible in the future for 'commissioning' Cumbria's health services through the Cumbria Clinical Commissioning Group.

'Closer to Home' has developed local services in line with its aspirations of:

- Helping people stay to stay well
- Offering early diagnosis and treatment
- Providing long-term support that helps people stay in control of their illness
- Providing more local hospital services
- Providing more appropriate emergency/urgent services

Thanks to the commissioning decisions of local GPs, community hospitals are delivering a greater range of services and clinics than ever before, to provide a bridge between treating a patient at home and care in the big acute hospitals.

Providing more services from our community hospitals means patients do not have to travel as far for some treatments, can be treated closer to home, can avoid being admitted to an acute hospital, or, if they are, they can then transfer back nearer to home much sooner.

Investment has been made across the county. A new health centre opened in Sedbergh in March 2012, a second in Cleator Moor will open in 2013 and a new community hospital will open in Cockermouth in 2013.

Integrated care will mean that services like GP surgeries, in-patient beds and minor surgeries will be delivered alongside other community services that could include, for example, a library, support from the third sector and children's services. This will bring big benefits to patients, allowing nursing teams and other professionals to work together to support people more effectively.

A Primary Care Assessment Service has been developed in Accident and Emergency Departments in Carlisle, Whitehaven and Barrow. The service allows GPs to refer patients to be observed for a longer period of time before a specific diagnosis or referral is made.

This will allow the hospital team to see if a patient responds to short-term treatment, such as intravenous antibiotics or rehydration treatment, before a decision is made over whether the patient needs longer term treatment or if they need to be admitted to hospital. It is designed to diagnose and treat minor injuries and ailments. Various tests such as chest x-rays and blood tests following referrals from GPs can also be performed as an out-patient facility.

Challenge 4_

A health system based on good intelligence

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 principal 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 straightforward to measure. Secondly, there is a preoccupation with process and 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 births and deaths, supplemented by hospital activity measures and some social surveys, is no longer adequate if we are to get upstream of threats to health.

In my foreword at the beginning of this report, I highlighted the research and intelligence work done in the previous five public health reports for Cumbria. I also alluded to a series of clinical service failures necessitating the convening of NHS gold or major incident responses.

The adoption of a contingency planning approach to clinical service failure has been necessitated by real concerns over the past six years. These concerns have surfaced as a result of public anxieties, but also from rigorous monitoring of routine data, as well as the commissioning of special reports.

The suspension of the breast screening service in North Cumbria was an action I had to take as a result of the weaknesses identified in the service and the impact that they were having on women.

A recent perinatal mortality review commissioned from an independent panel of experts looked at all perinatal deaths in the county in 2009 and 2010. It has found avoidable factors in about one third of these deaths, whether lifestyle related such as smoking and obesity, or service failures. It concluded that, although the overall statistics for perinatal mortality in Cumbria are better than both regional and national averages, we could do better in areas including attention to clinical leadership, training, assessment of risk and support for lifestyle change.

Serious service failures at Morecambe Bay hospitals have led to major interventions in their running and clinical management. In all these examples, the availability of good quality intelligence has been crucial.

The evidence base for a health system based on good intelligence:

One innovation which has helped to put Cumbria on a sound footing for intelligence has been the establishment of the Cumbria Observatory, a partnership of the NHS, Cumbria County Council and other agencies including district councils and the police.

The Observatory^v was officially launched in December 2008 and is providing comprehensive integrated intelligence on health and wellbeing, with the ability to profile intelligence at the varying levels of GP locality, electoral wards and divisions, district and county. We have also produced a series of pocket books of health and wellbeing statistics - this year 'Cumbria in Numbers: 2013'.

Complementing the work of the Observatory, NHS Cumbria has commissioned a series of lifecycle reports on the county from the North West Public Health Observatory at Liverpool John Moores University. The Cumbria Lifecycle Project^{vi} has produced a series of invaluable reports on Cumbrian health and wellbeing at different life stages:

- *Born in Cumbria*
- *Starting Sure in Cumbria*
- *Coming of Age in Cumbria*
- *Living Well in Cumbria*
- *Growing Older in Cumbria*
- *Mortality in Cumbria*

Other collaborations with John Moores University have included the Trauma and Injury Intelligence Group which analyses data from our hospital accident and emergency departments with an eye to prevention.

The reports generated from this work are of interest to other agencies, especially the police, with whom NHS Cumbria has enjoyed a close and productive relationship for the past six years.

Other projects in the pipeline in collaboration with Liverpool John Moores University include the employment of a research nurse to support clinical audit into serious untoward incidents and near misses, and a pilot of heroin prescription to drug users in one part of the county.

Serious Untoward incidents

Work on Serious Untoward Incidents and the related matters of children's and adult safeguarding is an area where good progress has been made in the Primary Care Trust over the past four years. This has been achieved by working within a public health framework with collaboration between the medical and nursing directors and increasingly close co-operation of hospitals and other service providers.

It has been recognised that, in Cumbria as a whole, the systems for safeguarding and for learning from Serious Untoward incidents including avoidable deaths have historically been weak. They have been compounded by poor relationships between some of the partner agencies and differences in organisational culture. Within the Primary Care Trust we took it upon ourselves to put our systems on a robust basis, creating a Hub for reporting Serious Untoward Incidents and related safeguarding matters. A weekly, multidisciplinary 'ward round' receives all new notifications, allocates a lead officer for investigation and liaison with the relevant provider, and performance chases the progress of investigation, lessons learned and closure. Monthly intensive one-to-one meetings are held with each provider in turn, including the hospitals, North West Ambulance Trust, Cumbria

Section 1_

Challenge 4_A health system based on good intelligence

Partnership NHS Trust and others, to ensure that all services in the county recognise the importance of taking a whole-systems approach to clinical failure. There is now board-level ownership of the pursuit of learning and quality.

GP level data

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 GPs 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.

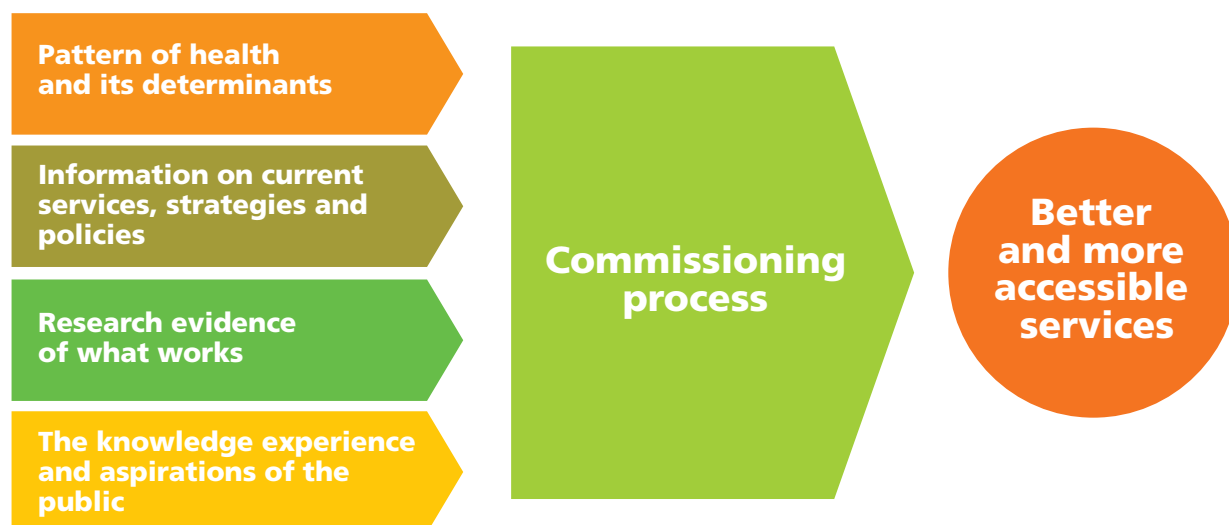
Joint Strategic Needs Assessments

Cumbria has also produced Joint Strategic Needs Assessments (JSNAs) in 2009 and 2012. The JSNA model in Cumbria is based on bringing together four sources of information (see diagram below), relating to the needs of people living in Cumbria, and using these to

influence how services are provided. The development of the JSNA programme in Cumbria has taken place in several stages. A web-based information resource^{vii} has been live for over four years and a number of needs assessment and public engagement projects, focused on specific communities and issues, have been completed. For example, needs assessments on the following areas have been completed since 2008

- Dementia
- Child Poverty
- Adult Mental Health
- Child Mental Health
- Suicide
- Poverty
- Gypsy and Travellers
- Sexual health

In Cumbria, building on the Asset-Based Community Development approach, we are moving beyond a reliance solely on assessments of need to include the mapping of individual and community assets for health and wellbeing.





Challenge 5_

Building capacity

Building capacity for health and wellbeing and for resilience in adversity starts with the individual, the carer and the family group. It is fundamentally cultural - a matter of habits, behaviours and practices.

Sometimes it seems as if we have forgotten this truth and regard professionals as the keystone of the health care system, when in reality the overwhelming majority of healthcare is informal and carried out by ourselves and those near to us.

A sustainable system must build on that with information, advice, education and training. This should be implicit in the hidden curriculum in the nursery, preschool, school and beyond. It is best when underpinned by evidence and robust research.

The 'Fully engaged scenario' as envisaged by Sir Derek Wanless^{viii} saw partnership and co-production between the public and professionals as the way forward. I have already referred to people's assets and we must support each person's health assets and the behaviours that go with them.

The three vehicles for public health - Total Place, Asset-Based Community Development, and Community-Orientated Primary Care - can be seen as pillars for protecting and improving health.

If we are to stop trying to 'fix' people and work with (not on) them, we must challenge and reorientate our education and training institutions and professional practice here in Cumbria, as elsewhere.

The evidence base for building capacity

In 2008, partnership working in Cumbria was focussed around the Local Area Agreement (LAA). This was the mechanism through which central government agrees with an area (in our case the county of Cumbria) the priority issues for improvement and the targets that should be achieved.

Health improvement in the Cumbria population was achieved through the LAA mechanism and through a series of district and thematic partnership groups. The partnership working was 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.

LAAs have now been scrapped and the launch of the Health and Social Care Bill is changing the delivery of public health from the 1st April 2013. The public health service is returning at least in part to the local authority home it left in 1974. Some public health will be moved to a new National Commissioning Board for the NHS and some services such as health protection will be moved to a new body called Public Health England.

Local Health and Wellbeing Boards are being established as the forum for key leaders from health and the care system to work together to improve the health and wellbeing of their local population and reduce health inequalities. It will oversee the whole health system in Cumbria, with responsibility for ensuring that the right services are being commissioned to address the identified need.

Since April 2012, Cumbria's Health and Wellbeing Board has been established in shadow form. It will take on its statutory functions from 1st April 2013.

The Health and Social Care Bill mandates a minimum Board membership of:

- one local elected representative
- a representative of the local Healthwatch organisation
- a representative of each local clinical commissioning group
- the local authority director for adult social services
- the local authority director for children's services
- the director of public health for the local authority

Board members will work together to understand the needs of their local communities, agree priorities to improve health and wellbeing and encourage the development of more integrated commissioning of services across health and social care. It is hoped that patients and the public should experience more joined-up services from the NHS and local councils as a result. The boards will also help give communities a greater say in understanding and addressing their local health and social care needs.

Boards will have a duty to involve local people in preparation of key documents, such as the Joint Strategic Needs Assessment, Pharmaceutical Needs Assessment and the Joint Health and Wellbeing Strategy. These documents are there to guide commissioners so that services are delivered where the greatest need is identified and in a joined up way.

Localities are also being supported to develop their own distinct Health and Wellbeing Forum, which could reflect a similar membership to the Board at locality level.

In Cumbria, the Health and Wellbeing Board will take its place alongside the other significant strategic partnership bodies, including the Adult and Child Safeguarding Boards, the Local Enterprise Partnership and the Safer Cumbria Group. This latter one has significant overlaps with the scope and reach of public health responsibilities - not least on approaches to drugs and alcohol, and injury and violence prevention.

The new system is designed to make a difference and to make best use of the resources currently there. Performance will be regularly monitored, but managing targets will not get in the way of the important role the Board has in delivering the strategy and amending the parts of the system which can be improved.



Keep healthy and carry on

We now move to the core theme of the 2013 report – *Those Who Have Served* - and ask whether the blitz spirit displayed by the veterans living in Cumbria today can be enough to sustain their health and independence moving into the later stages of their lives. This section explores some of the challenges, and means of supporting Cumbrian residents to enjoy good health in later life.

Section 2_

Keep healthy and carry on

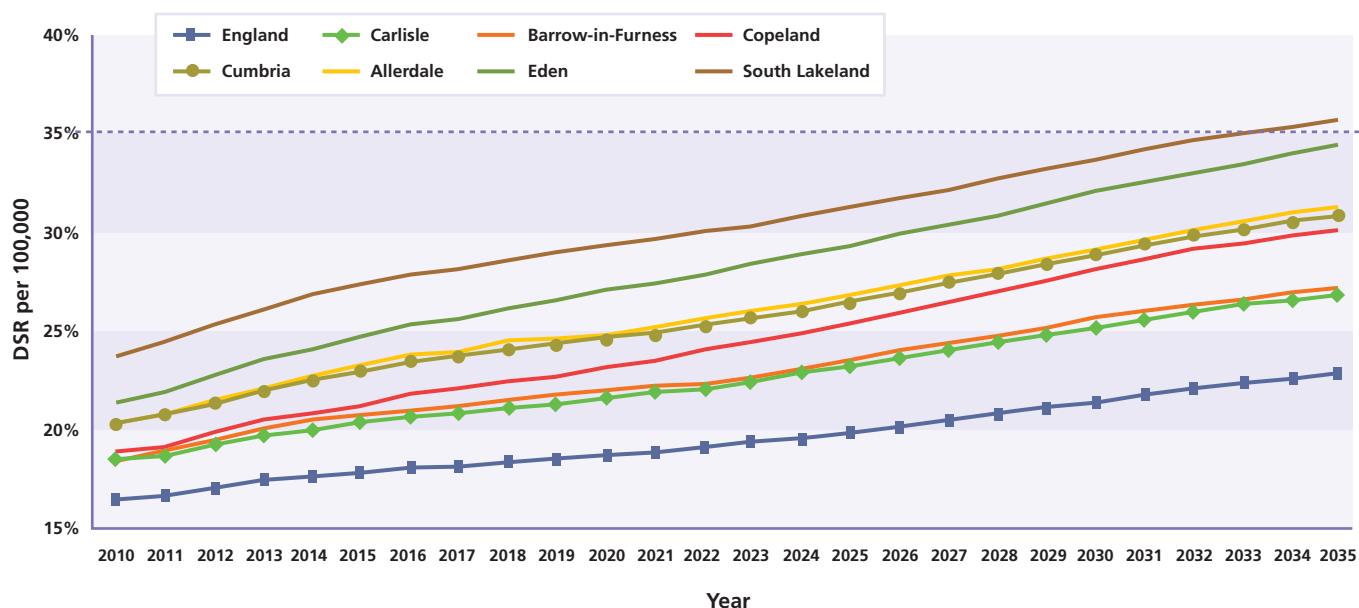
The population of Cumbria is older than the national average and the gap is projected to increase. By 2035 it is estimated that 31% of the population in Cumbria will be aged over 60 years, compared with 23% across England.

The number of older people will be significantly higher in those areas of the county such as Eden and South Lakeland, which already enjoy a longer life expectancy and attract a high number of retirees. The less affluent areas of the county are also expected to see an increased proportion of older people, exacerbated by the continued migration of younger people out of the county (see Figure 19).

The rise in life expectancy is a great achievement; however it does have significant implications for health and social care services in the future.



Figure 19: Change in the proportion of the population aged 65+, comparing districts with Cumbria and England



Source: Office for National Statistics 2010-based projections

1. Adult Social Care Reforms

People are living longer, and this is something to celebrate. However, the current adult social care funding system in England is not fit for purpose and urgent change is necessary.

Care costs can be high (one in four people aged 65 today can expect to spend over £50,000 on care in their lifetime). The current system is also confusing, unfair and unsustainable, and as a result, people frequently do not have good experiences of it.

From April 2017, there will be a cap on care costs, which aims to give everyone the reassurance that they will have a level of protection if they have the most serious needs and incur very high care costs. Due to the economic circumstances, the Government has decided to introduce a cap that is equivalent to around £61,000 in 2010/11 prices, which is above the £25,000-£50,000 range originally

recommended by the Dilnot Commission^{ix}, an independent panel set up to look at the fairest and most sustainable way to fund care and support in England. The cap is equivalent to £75,000 in 2017/18 prices. Up to 16% of older people are expected to face costs of £75,000 or more.

2. Dementia

There are currently estimated to be about 7,000 people living with dementia in Cumbria. This is expected to increase by 80% to over 13,000 by 2030. The increase will be highest in those districts with the greatest proportion of older people, such as South Lakeland.

At present only around 55% of those with dementia in Cumbria are identified on GP practice dementia registers. Figure 20 shows the number of people diagnosed, as a percentage of the number expected by locality.

Figure 20: Number of Cumbrians registered as having a diagnosis of dementia, as a percentage of the expected number.

	Allerdale	Carlisle	Copeland	Eden	Barrow	South Lakes
Number on dementia QOF register	750	850	363	391	695	1,004
Number on dementia register as a percentage of expected number	51%	63%	47%	50%	64%	54%

Source: Dementia Care Pathway Indicators, December 2012

Section 2_

Keep healthy and carry on

Whilst Cumbria's figure of 55% registered dementia patients is higher than the national average of 39%, work needs to be undertaken to improve detection and early diagnosis if the care of those with dementia is to be optimal and independent living maintained as long as possible. Currently around 80% of people diagnosed with dementia have had a care review in the previous 15 months, which again is slightly better than the national average.

Dementia has a major impact on the general health and wellbeing of the person and family and presents great challenges for both informal and formal carers. The National Dementia Strategy 'Living Well With Dementia'^x focuses on the outcomes that are important to people with dementia, their families and their carers. It aims to empower them to sustain their health and wellbeing and to lead the lives they chose, as far as possible, through the course of the illness. The strategy recognises that people living with dementia, their families and their carers are partners in the process of clarifying needs and solutions and, in some instances, meeting the needs of others.

Building on the National Dementia Strategy, the following issues are prioritised in Cumbria:

- Earlier diagnosis and good quality information to enable those living with dementia and their carers to fully engage in their care.
- The development of dementia-friendly environments and communities to promote independence.
- Improved quality of medical care, including the reduced use of anti-psychotic medication.

As part of Cumbria's Dementia Strategy, a Dementia Implementation Group has been established to oversee improvements in dementia care. To ensure that people with dementia, their families and carers can contribute to the work of the Implementation Group, the Alzheimer's Society in Cumbria has established a programme of local forum meetings. It is important that we build upon the service development work of the Dementia Implementation Group, by responding to the feedback provided by carers and people living with dementia. We also need to commission services that continue to improve the diagnosis, treatment, care and support offered to people living with dementia in Cumbria.

Case Study:

Cumbria Dementia Strategy - User Engagement Project

During 2012, a team from Stirling University worked with carers and people living with dementia in Cumbria, to explore their experiences of the condition.

A range of experiences were highlighted. For example, people valued the variety of support groups they could access and the opportunity to engage with peers in places like day centres. Some carers and people living with dementia reported having a positive experience of the process and delivery of diagnosis and they valued this, however others received very limited information, and had to learn about available support by themselves.

Recommendations, based on the feedback given, are being included in the work of the Cumbria Dementia Implementation Group.

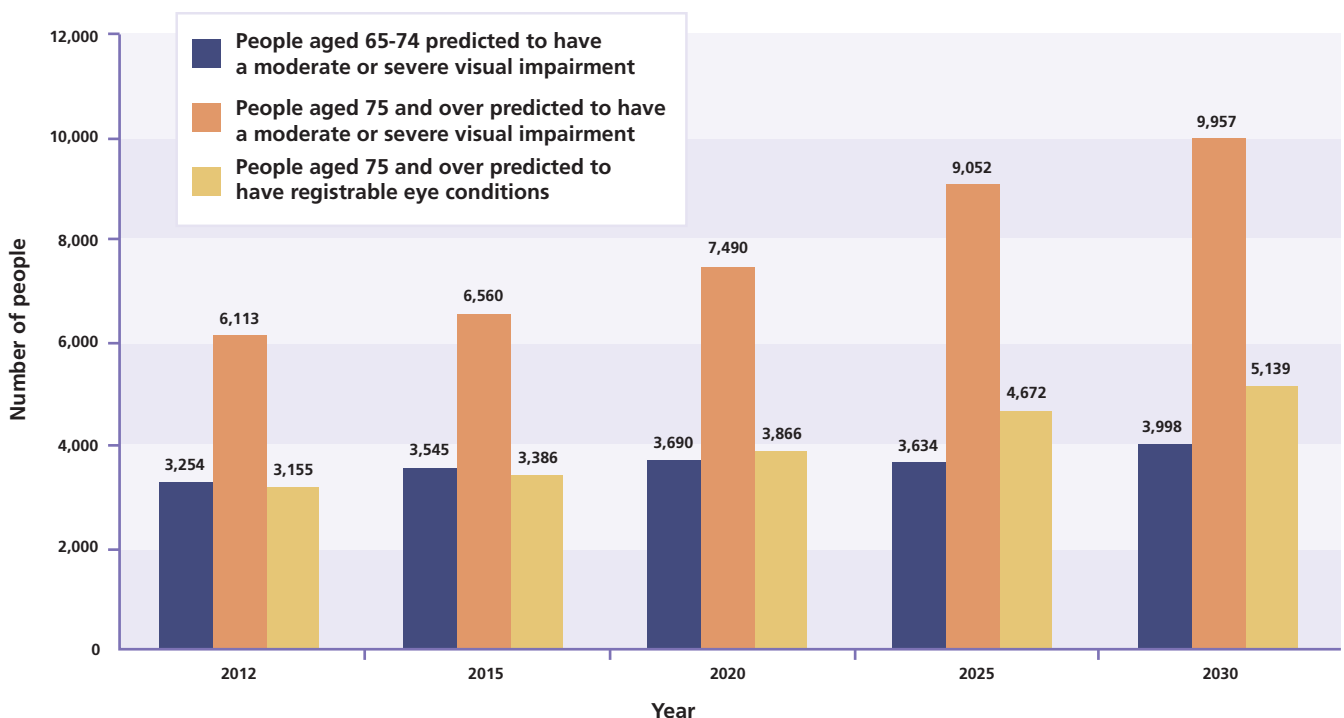
Older Adults and Sensory Loss

Last year we examined the predicted older people who are likely to have some kind of Sensory Loss and Visual Impairment. One of the recommendations from the 2012 report was to *“Build a picture of the size of the problem”* when referring to the number of people with sensory loss.

According to the research we are using for reference^{xi}, of those aged 75 and over, approximately half have correctable sight loss (such as cataracts or refractive error) and, if these are excluded, then 6.4% of over 75s have 'registrable' eye conditions. A small proportion have both cataracts and some other registrable cause of vision impairment, and these are included within the 6.4%.

Using ONS population projections, Figure 21 below shows the number of Cumbria residents aged 65 years and over predicted to have a visual impairment. The graph shows that the number of Cumbrians aged 65-74 predicted to have a moderate or severe visual impairment will increase by 23% over the next 18 years from 3,254 to 3,996 people. However, the number of Cumbrians over the age of 75 years with a moderate or severe visual impairment will also increase by 63% from 6,113 to 9,957 people. Understanding the extent of the issue is the first step to avoiding preventable sensory loss and ensuring high-quality life for those where prevention is not possible.

Figure 21: Visual impairment projections for Cumbria



Source: POPPI - PANSI

3. Social Isolation

Social isolation is common among older people. Alarming, 50% of older people (more than five million) in England report that the television is their main source of company.

There is increasing recognition of the impact that loneliness can have on health. In addition to depression, loneliness has been associated with:

- An increased risk of heart disease
- Greater risk of blood clots and dementia
- Reduced physical activity levels and increased alcohol consumption

Socially isolated and lonely adults are also more likely to undergo early admission into residential or nursing care.

In order for agencies to tackle the growing problem of social isolation and the impact it can have on people's health, the Department of Health has included a new measure in the updated Adult Social Care Outcomes Framework for 2013/2014. The framework measures the quality of care and support, and how well that care helps people to stay well, independent, and active in their communities. It is hoped that by mapping areas where loneliness is high, better care can be targeted at those who need it most and we can properly measure the levels of social isolation across Cumbria.

The new measure of social isolation is part of a national programme aimed at helping older people to stay healthy over the winter and reduce the increase in deaths generally seen during the winter months.



4. Winter Deaths

Excess winter deaths are defined as the extra number of deaths during the winter, compared with the non-winter months. Although it is assumed that excess winter deaths are associated with adverse weather, other countries in Europe, especially the colder Scandinavian countries, have relatively fewer excess winter deaths compared with the UK.

People living with underlying heart, circulatory or lung disease are at the highest risk of death during winter. People who live in more deprived areas, or those who are unemployed, may additionally be at risk of fuel poverty, which is also associated with excess winter deaths.

In Cumbria, there were 151 excess winter deaths in 2011/12. South Lakeland and Carlisle suffered the most excess winter deaths (64 excess deaths in Carlisle and 42 in South Lakeland - see Figure 22).

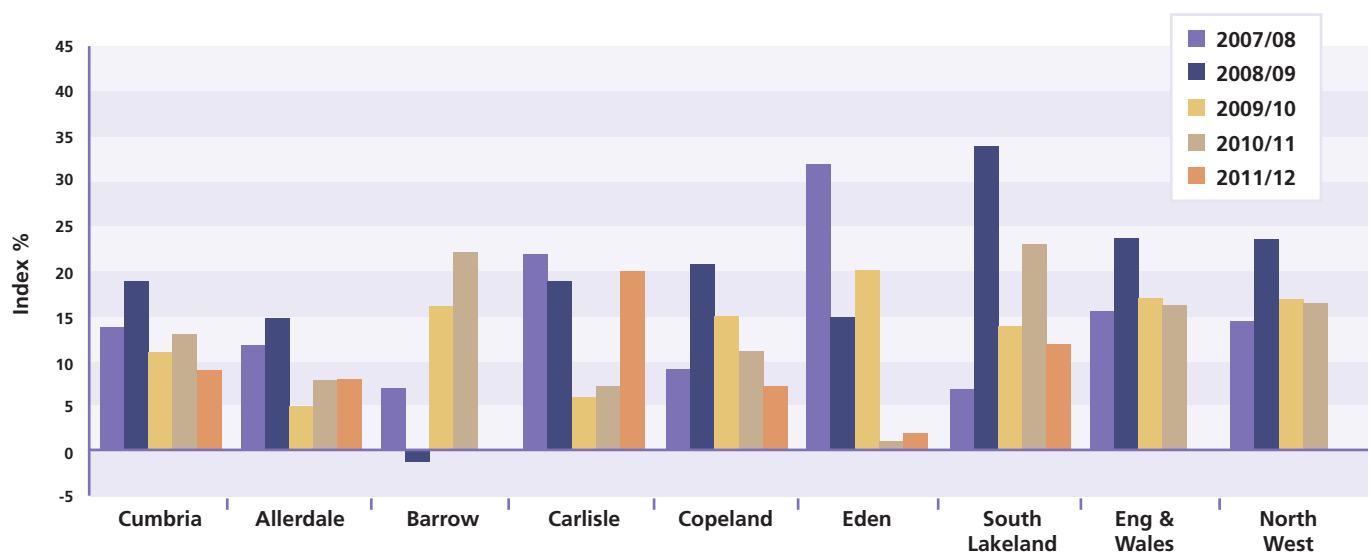
Within Cumbria, a number of services are in place to support wellbeing during the winter months. These include Choose Well (providing information to make sure that residents know how and where to get the best NHS care for any illness or injury), the annual flu vaccination campaign, COPD Winter Health Guide and help to stay warm, including advice on accessing Warm Front grants.

Case Study:

COPD Winter Health Guide

All people diagnosed with Chronic Obstructive Pulmonary Disease (COPD), who live in Cumbria, are sent a winter health guide. The guide provides information on how the weather can affect COPD, and outlines ways to prepare for, protect against, and prevent a worsening of symptoms.

Figure 22 – Excess Winter Death Index for Cumbria compared with England & Wales



Source: Cumbria Intelligence Observatory: Excess Winter Deaths Bulletin, September 2012

5. Dying with cancer, not from it

Over the last 50 years, the number of people dying from cancer has reduced significantly. In the early 1970s, only half of women with breast cancer would still be alive five years following their diagnosis. Now, however, it is nearly 9 in every 10. Bowel, prostate and skin cancer survival rates have also improved, and people with advanced cancer are now living longer, with better quality of life.

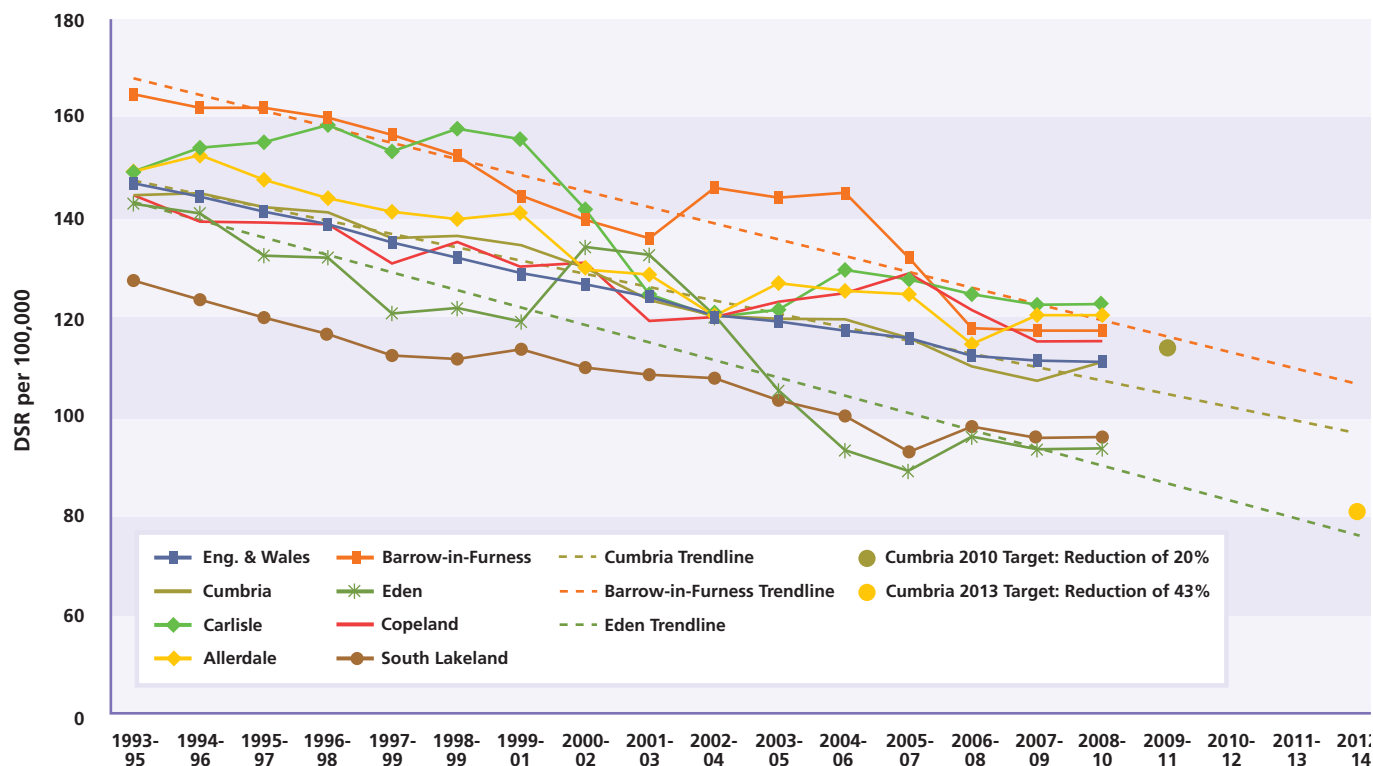
These remarkable improvements are the result of earlier detection and better treatment. It means that cancer is increasingly being seen as a long-term condition, with the focus shifting to providing support for independent living into later life.

It is not all good news, however, as survival rates for lung cancer remain poor. Fewer than 1 in 10 people diagnosed with lung cancer live for five years or more after diagnosis.

It is therefore important that we do more work to reduce premature deaths from lung cancer and commission services suitable to the needs of people living with long-term cancer.

Cancer is the biggest cause of premature mortality and deaths from cancer in people under the age of 75 varies markedly between districts. Rates are highest in Carlisle and Allerdale, see Figure 23.

Figure 23: Premature mortality from all cancers 1993-2010: Directly standardised rate per 100,000 population



Source: Office for National Statistics

6. End of life care

The ageing population of Cumbria will have an impact on end of life care services. These services support people with advanced progressive illness in the last six to twelve months of their lives and their families into bereavement. This includes pain management, as well as psychological, social, practical and spiritual support. In addition to specialist services, it is important that the elements of good end of life care are also integrated into all health or social care settings.

Figure 24 below shows the place and cause of death for those dying in Cumbria between 2008 and 2010. The highest proportion of deaths still occurred in hospital (52%), however most people express a preference to die in their own homes.

The Joint Commissioning Strategy for end of life care for adults in Cumbria sets out aspirations, including an opportunity for people who are approaching the end of their lives to express their views and preferences in a personalised care plan. For people with some conditions e.g. dementia, this should happen

at an early stage, soon after a diagnosis is confirmed, in order to allow people to consider and plan for their future care. This will allow them access to the same end of life care services as anyone else.

Case Study:

Advanced care planning for end of life

GPs hold End of Life Care Registers to support improved co-ordination of care. The register will include details of patients who the GP has identified as being in their last 6-12 months of their lives, or longer for patients diagnosed with dementia.

Being on the register prompts the GP to open up a conversation to encourage the patient to start thinking about their future and their preferred priorities of care. This may include the patient making an advanced decision to refuse resuscitation.

Information on end of life care is available from the National End of Life Care Programme^{xii}.

Figure 24: Place and causes of death in Cumbria 2008-2010

	All causes	Underlying cause of death			Causes mentioned on death certificate			
		Cancer	Cardiovascular disease	Respiratory disease	Alzheimer's/ Dementia/ Senility	Liver disease	Renal disease	Respiratory disease
Home	1,235	474	400	101	57	45	24	227
Care home	977	135	345	125	510	7	21	335
Hospital	2,827	658	983	410	282	130	186	1,101
Hospice	253	227	7	7	3	8	2	24
Total	5,422	1,521	1,776	648	871	193	233	1,705

Notes: i) 'Underlying cause' of death is the main cause of death recorded on a death certificate. "Causes mentioned" include the underlying cause and any contributory causes recorded. We have selected the most common underlying causes of death and the most common 'mentioned' causes that are demanding of end of life care. ii) While an individual will have only one recorded underlying cause, they may have more than one contributory cause recorded. iii) Numbers are annual averages.

Source: ONS Mortality Data 2008-10



The middle generations

Health needs, of course, are not the exclusive domain of older people and we must consider all age ranges – including the generations following *'Those Who Have Served'*.

As we all live longer, and because of the unhealthy lifestyles that many of us lead, more and more of us will suffer from long-term diseases such as cancer, stroke, heart disease and diabetes. The chances of developing these conditions depend to some extent on genetics, but there is a great deal that can be done in terms of lifestyle and screening that will reduce the risk of developing these conditions, or at least limit their severity.

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The middle generations

Long-term conditions

1. Cancer

In Cumbria, over 11,000 people are on the primary care cancer register at one time. Common male cancers are prostate (360 registrations per year), bowel (230) and lung (220). Common female cancers are breast (430), bowel (200) and lung (170).

By leading a healthy lifestyle, we can reduce the chances of developing cancers. The link between tobacco consumption and lung cancer is well-known, but excessive alcohol consumption can also increase the risk of some cancers (for example mouth cancer and breast cancer). As well as causing obesity, a poor diet can increase the risk of bowel cancer. By adhering to advice about eating a varied diet (with at least five portions of fruit and vegetables a day) and exercise (the government recommends a minimum of 30 minutes moderate-intensity physical activity, five days a week) we can reduce our risk of developing cancer.

Screening can also reduce the risk of dying from cancer. Well-organised and free screening programmes are available locally for breast cancer, bowel cancer and cervical cancer. A recent study in the *Lancet*^{xiii} showed that, by taking part in regular breast screening from the age of 50 until 70, women in the UK benefitted from a 20% reduction in breast cancer mortality.

Over the last few years, teenage girls have been offered a vaccination against Human Papilloma Virus (HPV) that will dramatically reduce the numbers of new cases of cervical cancer in years to come. The incidence of lip and oral cancers has risen from 14 in 1985 to 49

in 2009 and some of this is thought to be related to HPV infection being spread through oral sex. The HPV programme may have an effect on this trend.

2. Stroke

A stroke occurs when the blood supply to the brain is interrupted either by one of the blood vessels in the head bleeding or by becoming blocked by a clot that has travelled from elsewhere in the body. In Cumbria, approximately 600 people a year survive a stroke and there are over 12,000 people registered as having had a stroke in the past.

The risk of having a stroke is increased by high blood pressure, smoking and being overweight. People with heart disease or diabetes are also at increased risk. By having a healthy lifestyle and keeping an eye on blood pressure, we can reduce the risk of a stroke.

If you suspect someone is having a stroke, it is important to call for an ambulance quickly so that treatment can be given as soon as possible. The FAST^{xiv} campaign has highlighted the things that people should look out for:

- **F**ace – the face may have dropped on one side, the person may not be able to smile or their mouth or eye may have dropped
- **A**rms – the person with suspected stroke may not be able to lift one or both arms and keep them there because of arm weakness or numbness
- **S**peech – their speech may be slurred or garbled, or the person may not be able to talk at all despite appearing to be awake
- **T**ime – it is time to dial 999 immediately if you see any of these signs or symptoms

3. Heart Disease

Blockage of the coronary arteries that supply the heart with blood can lead to heart disease. To start with this can be a heavy chest pain or cramp on exertion called angina. This can progress over time to heart failure (when the heart can no longer pump efficiently) and a heart attack (where the muscles of the heart can't get enough blood and get damaged). The risk factors for heart disease are similar to the ones for stroke. High levels of some fats (cholesterol) in the blood can lead to heart disease, but the levels can be reduced by a good diet and in some people medication.

In Cumbria, 25,000 people are registered as having heart disease and each year there are 2,247 new heart attacks.

4. Diabetes

More and more people are now living with diabetes. There are two types of diabetes. In Type I diabetes, the cells in the pancreas that produce insulin are attacked by the body's immune system and leave the person unable to control their blood sugar. The incidence has been rising slowly over many years and each year about 2,200 Cumbrians (usually children) are diagnosed with diabetes. They require lifelong insulin which is either given by injections or by a pump.

Type II diabetes is much more common and tends to affect older people. Being overweight as a result of many years of unhealthy lifestyle is the main risk factor. In Cumbria there are 24,011 registered adult diabetics. To reduce complications of diabetes it is important to keep good control of blood sugar levels and to attend for regular health checks and retinal screening.

Mental health



Mental ill health can have far reaching impacts across generations. Poor parental mental health can increase the risk of mental health problems in children. The number of over 65s with depression is predicted to increase by about 5,000 to 7,000 people, and the number of over 65s with a learning disability is predicted to increase by about 1,500.

England's Mental Health Outcome Strategy 'No Health without Mental Health' (2012)^{xv}, highlights the link between good mental and physical health.

In a local context, Cumbria launched its own Strategic Framework, *Working Together for Wellbeing and Mental Health*^{xvi} in October 2011. Its twin objectives are that more people have good mental health and wellbeing, and that more people recover sooner from mental health problems. This will be done through a combination of early intervention, integrating mental health into primary care, and specialist recovery services.

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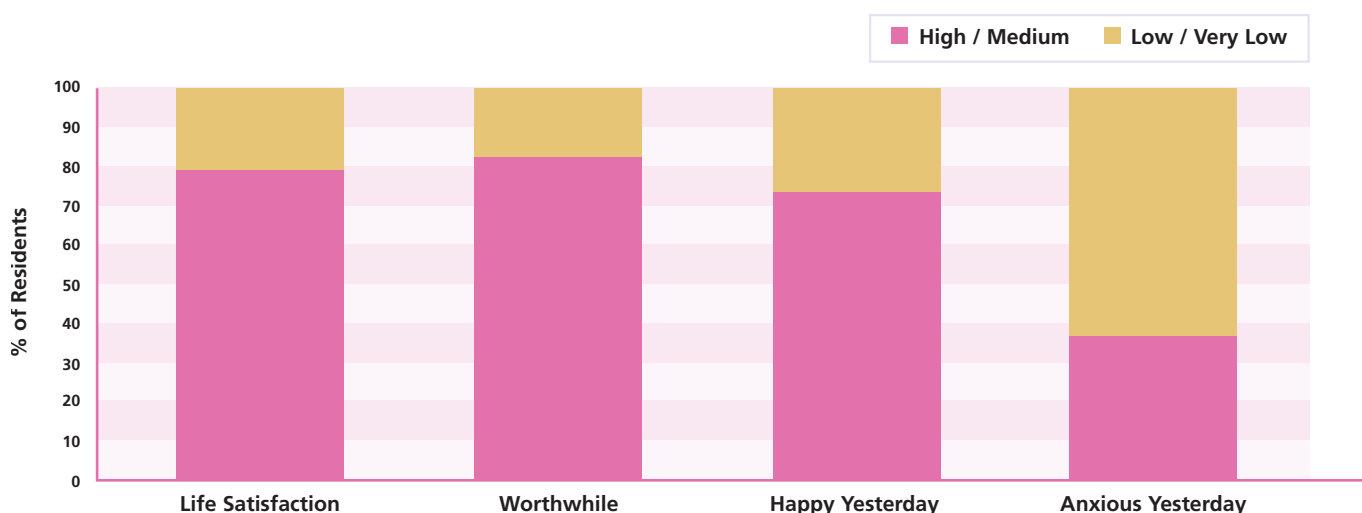
The pattern of wellbeing in Cumbria

Good mental health is more than the absence of mental illness. Wellbeing and resilience is not only important in itself, it also enables us to lead fulfilling lives and improves our physical health and relationships.

The Office for National Statistics (ONS) has developed the *Measuring the Nation's Wellbeing*^{xvii} programme, which aims to establish a fuller statistical picture of national wellbeing. The subjective statistics measure the wellbeing of individuals by finding out how people think and feel about their own lives.

Levels of wellbeing in Cumbria are higher than the national and regional average. Cumbria has the highest levels of life satisfaction, the highest proportion of people who were happy yesterday and the lowest proportion of people who were anxious yesterday in the North West region. The county has the second highest level of residents in the North West who feel that the things that they do in their life are worthwhile.

Figure 25: Proportion of Cumbria residents who report their wellbeing as high/medium and low/very low



Source: Office for National Statistics

Case Study:

Growing Well - a Cumbrian success story

Growing Well provides local people in South Cumbria with an effective, supportive and inclusive farm-based community that enables mental health recovery and wellbeing within the range of activities of an organic farm enterprise.

People recovering from mental health problems help farm six acres of Low Sizergh Farm under Soil Association organic certification, growing a wide range of seasonal produce which is sold to local people through a unique Crop Share scheme – also promoting healthy eating. The volunteers support a horticultural training programme and run a successful programme of farm visits for around 500 school children a year.

Participants volunteer their time for different activities at the farm, and many volunteers work for more than one day per week. Volunteers travel from all over South Cumbria as the farm is easily accessible by public transport - getting up and getting to the farm are important aspects of building new confidence and skills.

A strong emphasis is placed on Growing Well being managed in a co-operative and collaborative way. The volunteer team is encouraged to get involved in the farm's decision making at a practical level by taking on responsibility for tasks and supervision on site and at a strategic level within regular team meetings or by membership of the board of directors.

Growing Well is accredited for managing people on farms and is a City and Guilds centre for learning. It was named British Rural Enterprise of the Year in 2011, won the North-West Award for Sustainable Food and Farming in 2008 and was awarded Cumbrian Social Enterprise in 2008, 2009/2010. The development of the scheme has been supported by the Local Food fund of the Big Lottery.

Growing Well is currently delivering a pilot social prescribing project which allows the GPs of South Cumbria to refer patients to the farm to support them to improve their mental wellbeing. It also works with Cumbria County Council's Adult Services team and Adult Education Service to provide supportive placements for people requiring social care, and horticultural training for the general public.

One volunteer recently reported:

"From my first visit I was made to feel very welcome. Walking around the site, it became apparent very quickly how friendly the staff and volunteers I met were. I felt it was somewhere I could fit in and understood the down to earth nature that Growing Well was trying to achieve. Their enthusiasm was contagious. I know it might sound clichéd but I soon realised it was a place I could just be me."

For more information please visit www.growingwell.co.uk

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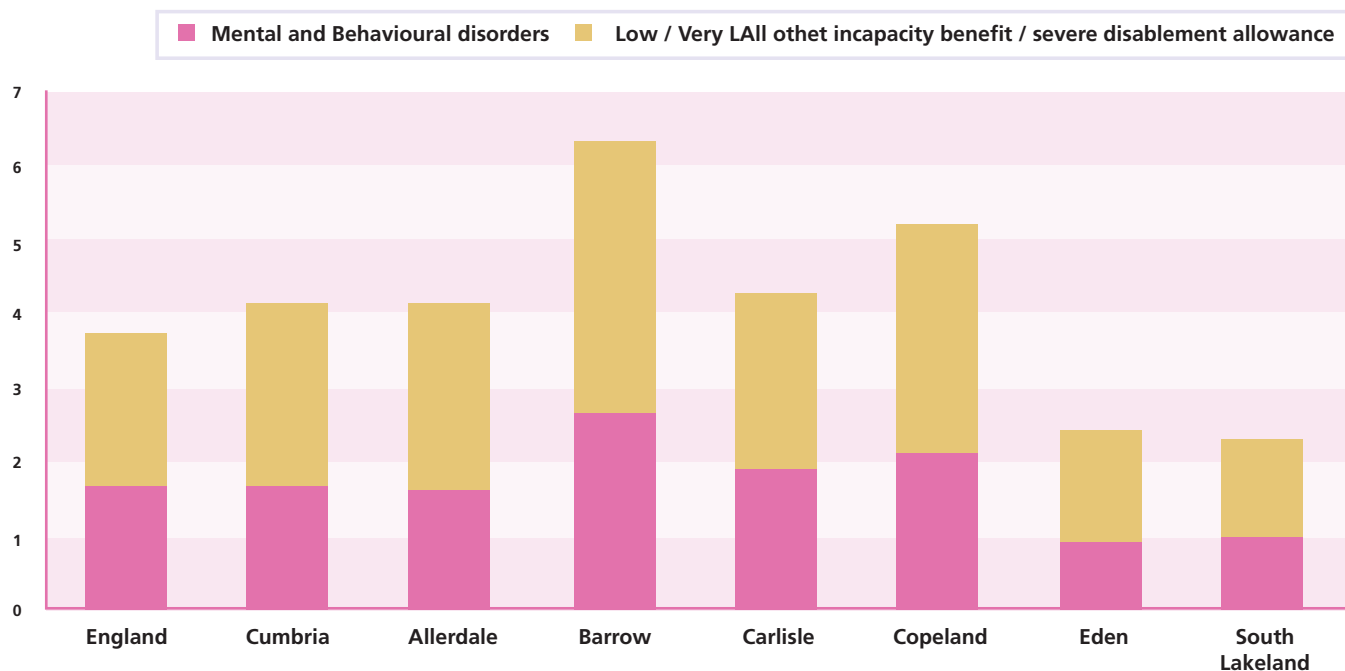
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Impact of the recession

Cumbria, in common with other parts of the global economy, is also being affected by the economic downturn. There were 9,615 Job Seeker Allowance (JSA) claimants in Cumbria in January 2012, a rise of 1,248 (14.9%) over the year, the highest number since July 1999. Nearly a third of all claimants (3,165) were aged 16-24. However Cumbria's JSA rate of 3.1% is less than the North West average of 4.6% and the UK average of 4.1%. Rates are highest in Barrow (4.4%) and Copeland (3.9%).

High numbers of Cumbrians are out of work because of mental ill health, especially in more deprived urban areas. As Figure 26 below shows, rates of benefit claimants both for any condition and for mental health and behavioural conditions are particularly high in Barrow, and are also higher than the national average in Allerdale, Carlisle and Copeland.

Figure 26: Percentage of the population aged 16+ claiming incapacity benefit or severe disablement allowance, January 2012.



Source: NOMIS

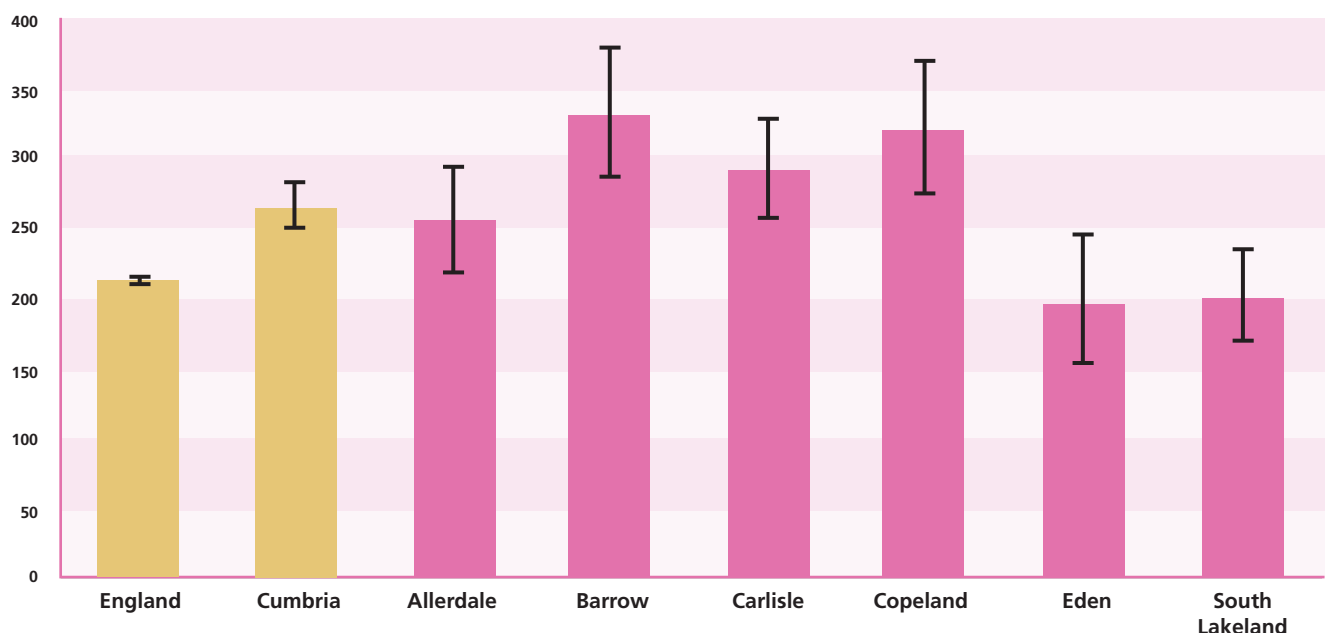
Self harm

Self harm is an important health concern in its own right. However, a wide range of psychiatric problems, such as borderline personality disorder, depression, bipolar disorder, schizophrenia, and drug and alcohol use disorders are associated with self harm. Furthermore, self harm has been shown to increase the likelihood of suicide by between 50 and 100 fold.

In Cumbria, there were 1,592 accident and emergency department attendances for self harm in 2010/11, of which 56% were female. The highest rates of self harm attendances occurred in females aged 10-19 and in males aged 20-29.

The 2010/11 directly standardised rate of emergency hospital admissions due to self harm in Cumbria was 265.6 per 100,000 persons. This was statistically significantly higher than the national rate of 212 per 100,000 persons. Furthermore, rates of self harm in Allerdale, Barrow, Carlisle and Copeland are statistically significantly higher than the national rate, see Figure 27.

Figure 27: Emergency hospital admissions for intentional self harm, directly age standardised rate for 2010/11



Source: NHS Information Centre

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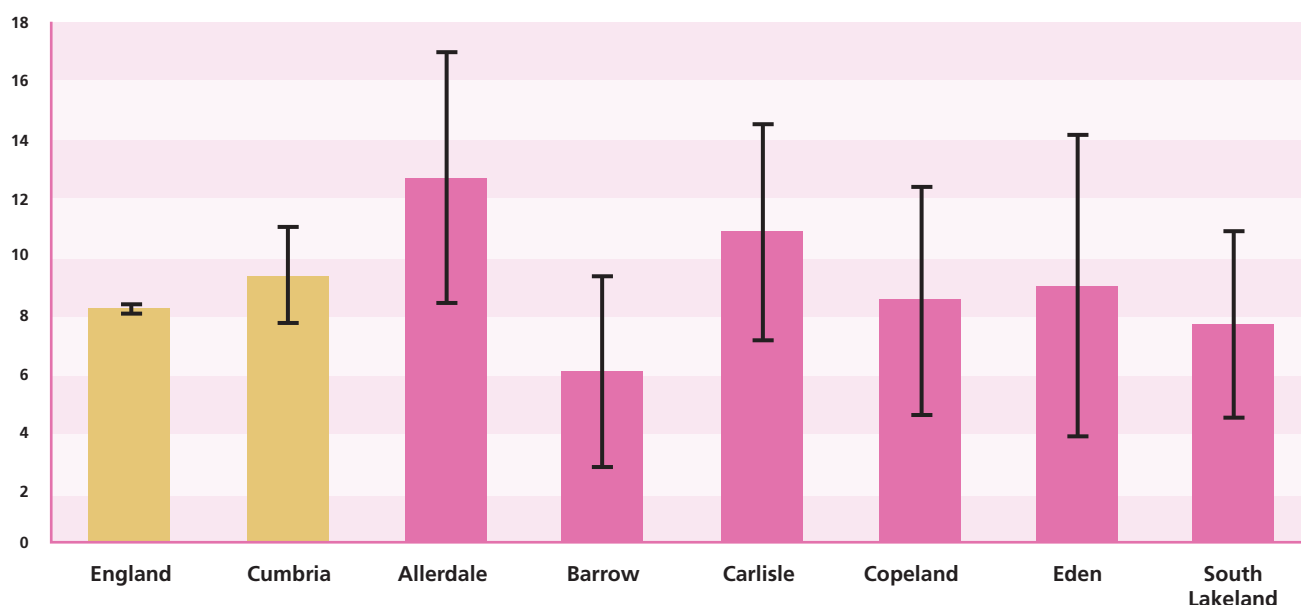
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Suicide and suicide prevention

The worst possible outcome for people suffering from mental illness is suicide. On average over the past 15 years, 57 people have died through suicide each year in Cumbria – around 10 to 15 people higher than the national average.

Although deaths through suicide are decreasing and represent only 1% of all deaths in Cumbria, they account for about 6% of years of life lost to premature death. Within Cumbria, deaths from suicide range from 12.4 per 100,000 persons in Allerdale to 5.8 deaths per 100,000 persons in Barrow, see Figure 28. Suicide rates are highest in older people (aged 35-64), especially males.

Figure 28: Deaths per 100,000 population from suicide and injury of undetermined intent, 2008-10



Source: NHS Information Centre

The first suicide prevention strategy for Cumbria was produced in 2009. Much progress has been made since then, including:

- **Training for professionals and community 'gatekeepers':** Carlisle and Eden MIND was commissioned by Cumbria County Council and NHS Cumbria to deliver the evidence based ASIST, safeTALK & suicideTALK courses countywide for 18 months from May 2012.
- **Support for those bereaved through suicide and post-suicide interventions:** With the help of the national charity, Survivors of Bereavement through Suicide (SOBs), Cumbria Mental Health Group set up a support group for people bereaved through suicide which has now been running for two years. Recent achievements include work with the Cumbria library service to begin stocking a collection of suicide bereavement support books recommended by SOBs.
- **Samaritans:** Samaritans has successfully piloted a 'Step by Step' post-suicide intervention service for schools.

Preventing Suicide in England: a cross government outcomes strategy to save lives^{xviii} was published by the Department of Health on 10 September 2012, World Suicide Prevention Day. The Cumbria Suicide Prevention Strategy is in the process of being updated in order to align more closely with these national priorities.

Case Study:

Post suicide intervention

Following the suicide of a young person in Cumbria, a public health response was set up to ensure that agencies continue to work together to support the emotional health and wellbeing of those communities affected by the tragedy, and specifically to prevent further suicides among local children and young people.

This took the form of a multi-agency response centred on the school and involving the mapping of vulnerable groups and communities, working with the local media, and developing an enhanced surveillance system.

This work was complementary to statutory safeguarding processes and to existing support received by the family and others directly affected.

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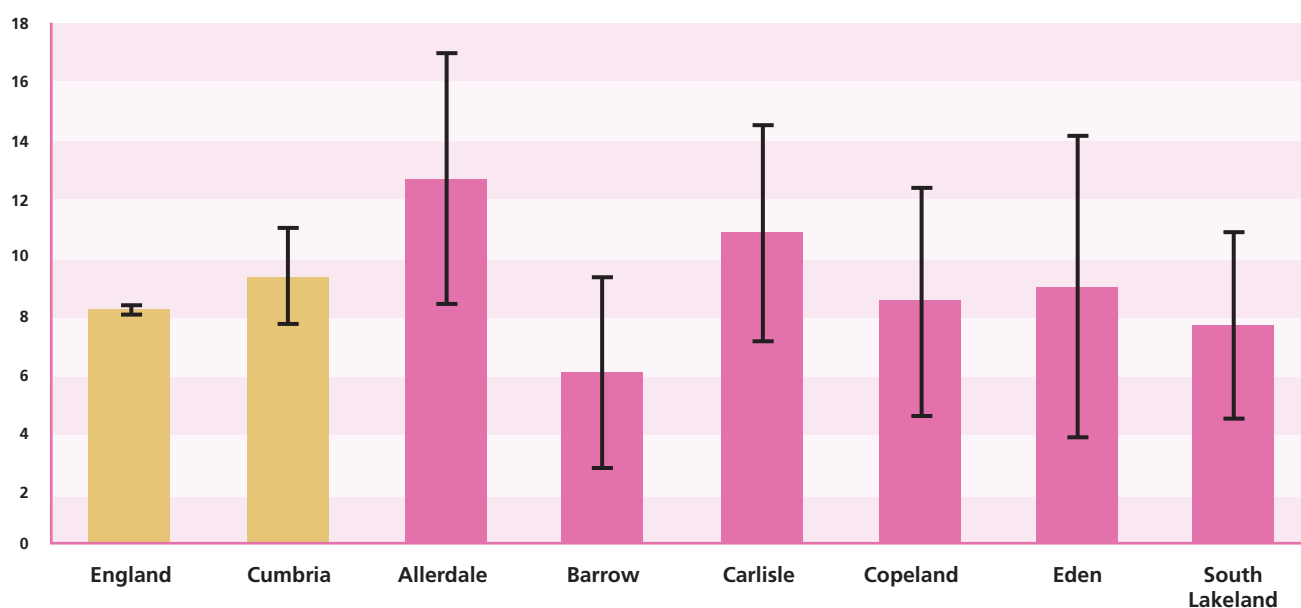
Substance misuse

There is a close relationship between alcohol and drug misuse and mental health problems. People with mental health problems have a higher risk of drug and alcohol problems and vice versa.

- Alcohol-attributable hospital admissions

Data for 2010/11 shows that in Cumbria there were 1,924 hospital episodes per 100,000 population due to alcohol-attributable conditions. Across Cumbria, the highest rate was observed in Barrow, where it was statistically significantly higher than other Cumbrian districts, see Figure 29.

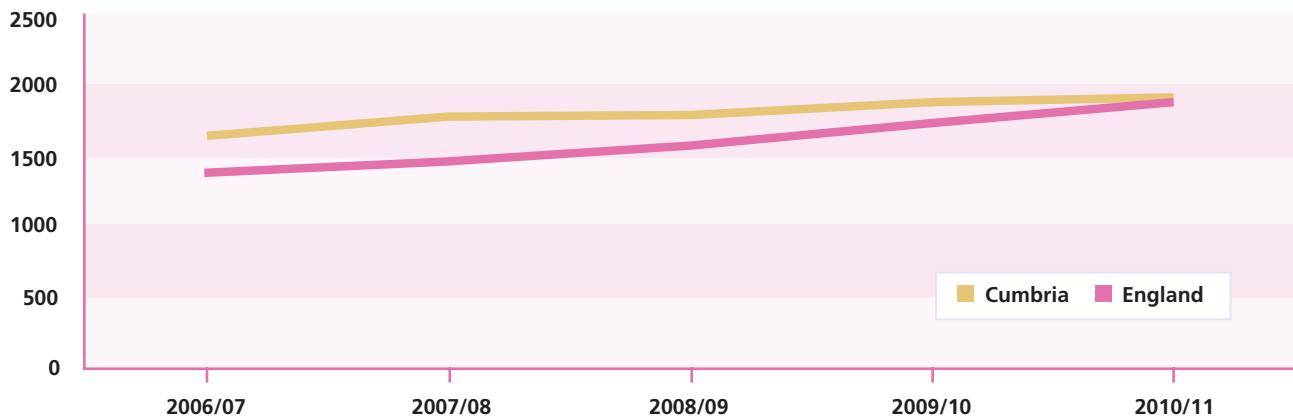
Figure 29: Hospital episodes for alcohol-attributable conditions in 2010/11, directly standardised rate per 100,000 persons, all ages.



Source: NWPHO Health Profiles

Trend data also reveals that the rate of alcohol-attributable hospital episodes is increasing in Cumbria, but the gap between England has been gradually closing over time, see Figure 30.

Figure 30: Trend of hospital episodes for alcohol-attributable conditions, directly standardised rate per 100,000 persons, all ages.

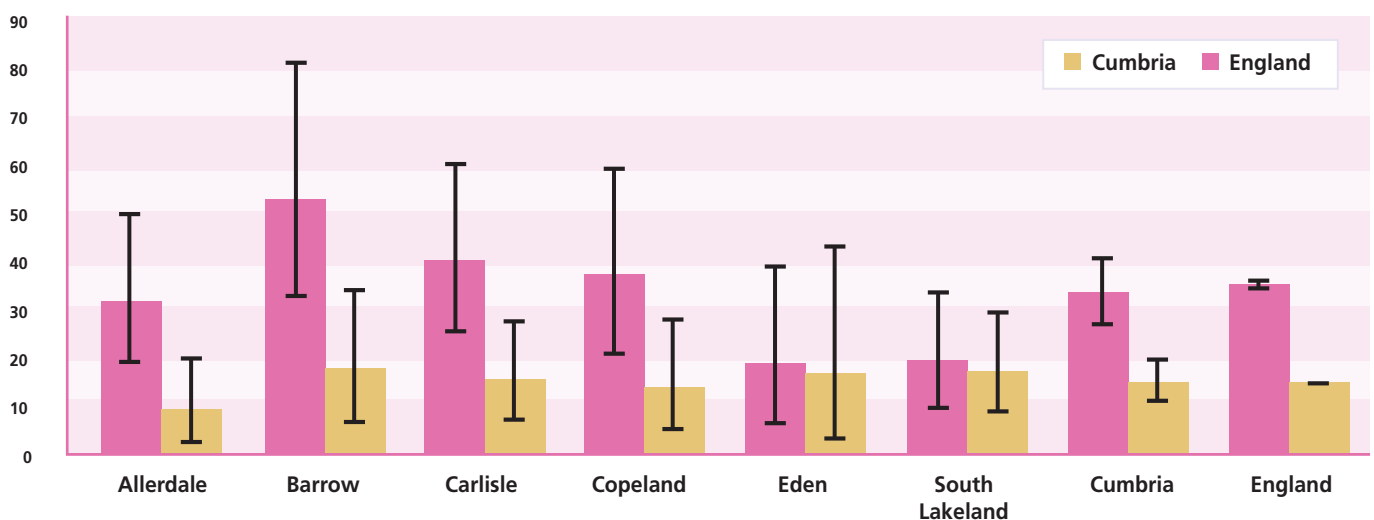


Source: Local Alcohol Profiles for England (LAPE)

- Alcohol-attributable mortality

Alcohol-attributable mortality is a useful indicator of the health burden caused by harmful consumption of alcohol. In 2010, there were 172 deaths attributable to alcohol in Cumbria. Across Cumbria the rate of mortality is higher in males compared with females, see Figure 31.

Figure 31: Deaths from alcohol-attributable conditions, directly standardised rate per 100,000 population, all ages



Source: Local Alcohol Profiles for England (LAPE)

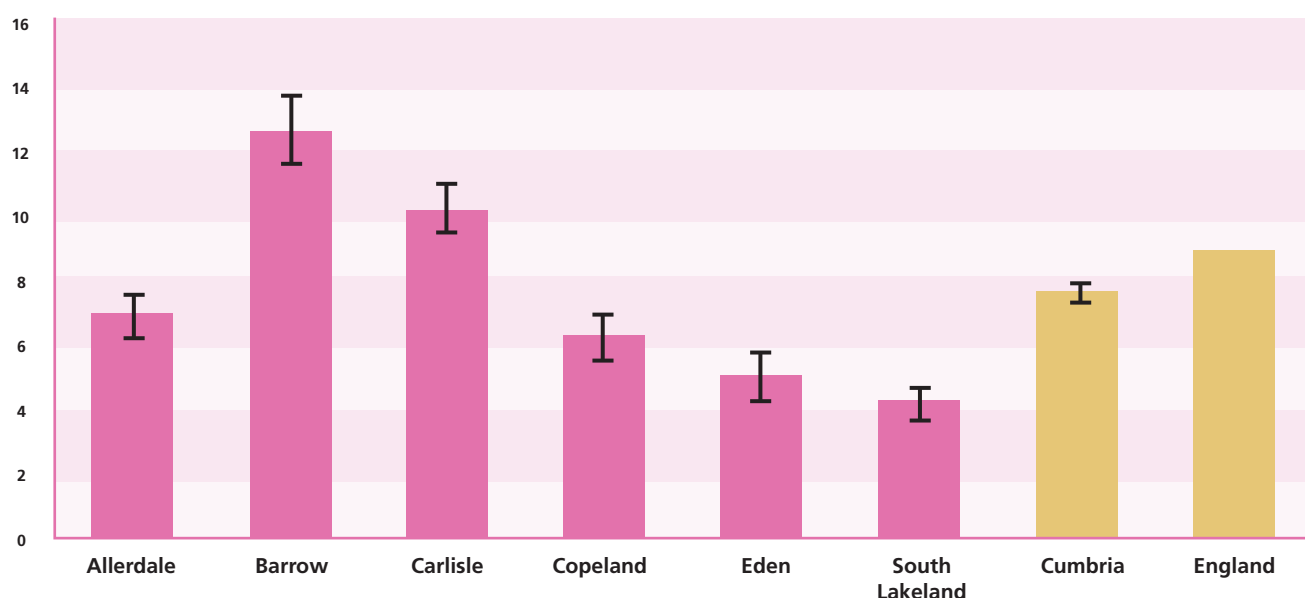
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- Drug use

The estimated rate of drug use (opiates and/or crack cocaine) in Cumbria during 2009/10 was 7.6 per 1,000 persons aged 15-64. This was lower than the national rate, however there are some large disparities across Cumbria, as illustrated in Figure 32. Barrow had the highest estimated rate of drug use (12.6 per 1,000) while South Lakeland had the lowest estimated rate of drug use (4.2 per 1,000).

Figure 32: Estimated prevalence of drug misuse (opiates and/or crack cocaine), per 1,000 persons aged 15-64, 2009/10



Source: NWPFO Health Profiles



- Drug and Alcohol Service Users

Throughout 2011-12 1,783 users came into contact with the Cumbria Drug and Alcohol Action Team (DAAT), an increase of 14 users from the previous year. Over two-thirds of users were male, and the majority were aged between 35-39 years. In Cumbria the most prevalent drug stated by people accessing treatment was heroin, at 71.7%.

For alcohol service users, the demographic picture was very different. There were 1,167 residents of Cumbria in contact with structured alcohol treatment, of which 40% were female,

with an average age of 40. Nearly 66% of individuals in structured treatment consumed over 200 units of alcohol per month.

Historically, drug and alcohol issues have been seen as two different problems, with the most common method of treating drug problems being medication. Within Cumbria it has been recognised that there are significant similarities and crossovers when dealing with drug and alcohol issues and that the best way is through a recovery-based methodology which addresses the client's individual needs.

Case Study:

Life Matters

In April 2012 the Life Matters project was introduced in Cumbria to facilitate early interventions and support, and to help adults with mental health concerns including stress, anxiety and depression.

Supported by NHS Cumbria and Cumbria County Council, together with a range of voluntary and third sector partners, it has introduced a range of services to help people experiencing poor mental health.

The project recognises that prevention can have an impact on the whole population - raising awareness and encouraging wellbeing. It also encourages and supports rehabilitation - building confidence and aiding recovery.

For individuals who have early signs of mental ill health or are trying to manage a condition such as depression or anxiety, the project aims to help reduce the need for hospital services and reduce reliance on medication.

For those who are likely to be on a longer recovery and rehabilitation pathway, intervention will support their discharge from services, assist rehabilitation and provide support to help people return to independent living such as getting back to work.

Feedback so far includes:

"Huge sense of achievement. At the end of the course I felt on a new journey, with a belief that could try new things, meet more people and go from 'strength to strength..."

This project aims to help people in a number of ways:

- Avoiding hospital admission
- Improving partnerships such as with housing, leisure, employers and employment services
- Helping to prevent unemployment as a result of mental ill health
- Helping people to return to work following sickness absence
- Contributing to fewer people attempting suicide
- Improving the quality of information for patients and community support staff

Life Matters works across the county and GPs can refer patients to a range of support such as:

- Employment support
- Bridge building 1:1 support
- Courses
- Information and support hubs
- Leisure activities including arts, singing, dance, horticulture, yoga, tai chi.
- Focused support including bereavement support, family counselling, post natal wellbeing, telephone coaching, drug and alcohol recovery, self-harm, eating disorders, sexual abuse, domestic violence and isolation.

Activity levels have already exceeded 1,700 people entering the programme. Over 250 people have been trained around suicide prevention.

Sexual health



Risky sexual behaviour increases the chance of unplanned pregnancies and can lead to sexually transmitted infections. There are around 2,500 new sexually transmitted infections a year in Cumbria. Of these, there are about 500 cases of genital warts and 1,400 chlamydia infections. Diagnoses of gonorrhoea (65 a year) and syphilis (5 a year), appear to be reducing slightly.

As HIV treatments have improved, it has become more of a chronic disease for many people rather than the rapidly-fatal infection it once was. Currently around 150 people are living with HIV in Cumbria.

Some potential areas of improvement in sexual health could include establishing a multi-agency commissioning group to ensure joined up sexual and reproductive health and education commissioning across sectors. We could also increase the scope of community pharmacies to provide sexual health information, advice and treatment. And the enhancement of Sexually Transmitted Infection testing and contraception should be encouraged in General Practice, particularly within areas that have higher estimated sexual ill health, based upon population structure, to provide increased access and choice.

Section 4 will look in greater detail at the sexual health of younger people.



The future generations

So what does the future hold, and how will the health needs of children today differ from the '*Those Who Have Served*' generation? In this section we examine some of the public health issues relating to younger people and what they have learned (or forgotten) from the generations before them.

The birth experience and community midwives

Women have been helping each other deliver babies since time immemorial, more often than not with only life experience to guide them. By the early 20th century, most births were still at home, but attended by midwives. As the century progressed and obstetricians' roles became more defined, the number of hospital births increased and home births decreased. The biggest decline was between 1963 and 1974, when home birth rates dropped from 30% to 4.2%. Today only one in 40 women give birth at home, compared with one in three 50 years ago.

General improvements in healthcare, but more specifically in midwifery and neonatal intensive care have contributed to the significant improvements in infant and maternal mortality rates. However, despite the downward trend, the Marmot review *Fair Society, Healthy Lives*^{xix} noted that factors including births outside marriage, maternal age under the age of 20 and deprivation were independently associated with increased risk of infant mortality.

While infection and hygiene were significant threats to women and their babies in the past, modern pressures are much more related to lifestyle: smoking in pregnancy; poor nutrition before, during and after pregnancy; poverty and social deprivation; and low rates of breastfeeding. The number of women giving birth in their 40s is also increasing, as is the number of women electing to have a caesarean section, with both having implications for health outcomes.

Government policy is for all women to have a choice about where they give birth – be it at home, in a midwifery-led unit, or in a hospital. In a county such as Cumbria, with its sparse population and big distances, it is a particular challenge to enable all women to have the same high standard of maternity care as it is possible to provide in a big city.

Case Study:

Breastfeeding peer support project

Breastfeeding peer support projects have been targeted at the areas of Cumbria with the lowest breastfeeding rates. The projects are being hosted by the children's centre providers in each locality (Action for Children in Barrow, Howgill in West Cumbria and Barnardo's in Carlisle). Each of the pilots is structured differently and incorporates antenatal and postnatal contact, through a combination of face-to-face and telephone support. The pilots, which were funded from Health Gain grants until the end of March 2013, are yet to have a full evaluation of their impact.

Immunisation and vaccination

After clean water, vaccination is the most effective public health intervention in the world. It has saved more lives and prevented more serious diseases than any other medical advance in recent history, successfully tackling smallpox and putting polio on the brink of eradication. However, diseases such as measles, mumps and whooping cough remain a risk, and Cumbria is not alone in having seen an increasing number of cases of these illnesses during 2012.

Generally, the United Kingdom has an enviable record on achieving high vaccination uptake rates, with some areas of Cumbria achieving some of the best uptake rates in the country. It is a matter NHS Cumbria takes particularly seriously, encouraging its own clinical and support staff to have regular vaccinations. Nevertheless, some areas of the county and some harder-to-reach groups have seen lower uptake of some vaccines than would be ideal.

The general reduction in vaccine uptake in recent years has probably been caused by controversies around vaccine safety, and also a sense of complacency as epidemics of the most serious infectious diseases are a distant memory (largely thanks to vaccination programmes).

But 2012 has proved to be a year where any complacency in assuming that vaccination now prevents the spread of diseases has been challenged.

Measles, mumps and rubella (MMR) vaccine

This year we have seen more measles cases than for many years, with 31 cases (compared with none in 2011 and one in 2010). These cases were following an outbreak of over 300 cases in Liverpool and the surrounding areas, which appears to have spread to Cumbria (the first two cases in Cumbria were in people who had been to a football match in Liverpool).

Uptake of MMR has remained high overall in Cumbria, and we were very pleased that these cases did not spread to the wider community. Later in the year we saw some cases of measles on travellers' sites in Cumbria. Our health care professionals played an important role in working with the traveller groups to try and reduce the spread of disease, with nurses providing advice and support to parents and even offering MMR vaccination in the home setting where appropriate. This input was broadly welcomed, and we saw a definite improvement in the uptake of vaccine. Nevertheless, we did see a further isolated spread of measles, with a significant number of children requiring hospital admission, all of whom have now made full recoveries.

Of the 31 measles cases in Cumbria, nearly all were in people who had not been vaccinated with MMR or not had the second MMR vaccine. Some of these had not been vaccinated because they were too young (ie under one year olds), and some through parental choice. Although the MMR vaccine is suitable for nearly everyone, there are a few people who have problems with their immune systems who can't be vaccinated and therefore have to rely on others being vaccinated to prevent the spread of any disease.



As well as measles, 2012 also saw 33 cases of mumps in young people aged 13 -18 in a single school in South Lakeland. Once again, our health care professionals played an important role in offering advice and support to parents, young people and school staff. They also assisted with vaccination sessions and helped contain these cases to one area.

We continue to promote the importance of children having two doses of MMR vaccine, the first at one year of age and the second prior to starting school. Cumbria has continued to maintain a 95% uptake rate for MMR in children aged two years, but we are still working on ensuring that all of these children receive the second dose of vaccine at 3½ years. This second dose of vaccine is important to ensure the best possible protection. It is never too late to have children and young people vaccinated against MMR.

Vaccination during pregnancy

Over the past few years, the national vaccine programme has expanded to include flu and whooping cough vaccines for all pregnant women, and this is an area where Cumbria is leading the way in the north.

During pregnancy women's immune systems are depressed, this is nature's way of helping prevent the foetus from being rejected. This puts them at an increased risk of catching illnesses such as flu. We now know that, if a pregnant woman does catch flu, she has a much higher chance of having complications and requiring hospital treatment than someone who is not pregnant.

Vaccinating pregnant women also allows the mother to pass protection to her unborn baby, providing vital protection for the first six months of the baby's life while it is too young to be vaccinated directly. This is true for both flu and whooping cough.

Since 2010 there has been an increasing number of people contracting whooping cough both in the UK and abroad. 2012 saw a rapid rise in whooping cough cases, particularly among young babies. Whooping cough is a serious disease that can lead to pneumonia, permanent brain damage and even death.

It is pleasing to see that Cumbrian women are taking these messages about the health of their unborn babies extremely seriously and latest figures show that 78% of pregnant women due to give birth in December 2012 had been vaccinated against whooping cough. This is one of the highest uptake rates in the north, but it is necessary to continue to stress the importance of this vaccination in the hope of increasing the uptake still further.

Cervical cancer (HPV) jab

This vaccine was introduced in 2008 in schools, for girls aged 12 -13, and is the first vaccine to protect against cancer. It is pleasing to see that uptake in schools is over 90% as the vaccine is expected to be at least 70% effective at preventing this type of cancer. However, because it does not protect against every type of HPV, it will be important for young women to continue to attend cervical screening when invited. This vaccine is only available to those under 18 years, older women need to remember that regular cervical screening offers the best chance of preventing cervical cancer developing.

Ongoing development of vaccines

Some exciting developments are expected in the vaccine programme over the next two or three years – both in the diseases being protected against and the way vaccines are administered.

Rotavirus vaccine: This is a new vaccine that is given as drops, not via a needle. Once given to babies as part of the normal vaccine programme from the age of two months, it will protect them against a nasty diarrhoea and vomiting illness that caused 14,000 cases of diarrhoea and vomiting in under fives last year, with one in 10 of these babies and young children ending up in hospital.

Nasal flu vaccine for all children

aged 2-16: We are also expecting the flu vaccination programme to expand to include all children aged 2 -16 years. It will be given to children via a nasal spray rather than a needle. This is a new vaccine for the UK, although it has been widely used in the USA. It will take several years for the UK to be able to produce enough of this vaccine for all children, so its introduction will not be until 2014 at the earliest. All children with underlying health conditions will continue to be encouraged to have a standard flu vaccine until the new ones are available.

Meningitis: We are anticipating that we will be offering more protection against Meningitis C, through the addition of an extra dose of vaccine to ensure the best possible long-term protection. We may even be able to offer better protection if the new Meningitis B vaccine proves to be as successful in trials as is currently hoped.

Diet and physical activity in children

The importance of a healthy diet and being physically active for children and young people in Cumbria is a key public health issue. However, the rapid increase in levels of childhood obesity^{xx} show that in Cumbria over a third of children and young people are overweight or very overweight by the time they reach the end of primary school.

During the past 50 years, changes to work patterns, food production, food sales and the technological revolution means that, for an increasing number of young people, weight gain is inevitable. Where previous generations went to school in local villages and towns, the opportunities for walking or cycling to school have diminished as parental choice over schools has increased, exacerbated further by safety fears for children.

There is recognition across the NHS that active lifestyles are now an intrinsic part of 21st century healthcare. Physical activity provides important health benefits for children and young people and the current guidelines^{xxi} recommend that children and young people should aim for at least 60 minutes a day of moderate to vigorous intensity physical activity and they should minimise the amount of time they spend sitting for extended periods.

Case Study:

Carlisle Cooks!

This initiative, part of Carlisle's Healthy City programme, was delivered by a multi-agency steering group and took an early intervention 'cascade' approach to encourage education and training around preparing healthy meals.

It was targeted in areas of the city where child poverty and the uptake of free school meals were concerns. Behind the scheme were representatives from Barnardo's Carlisle Children's Centre (West), Botcherby Healthy Living Initiative, Carlisle City Council (including support from local councillors), Cumbria County Council's Children's Services team, and the Co-op.

Initially a two-day training event on healthy eating, food safety and food preparation was held for 20 cooks – who were largely local community-based workers and volunteers who were enthusiastic about supporting parents, families and carers of under-4s to improve their health and wellbeing.

Each cook then went on to run at least 12 cooking sessions, and three community cooking events, with support from a project co-ordinator. Between March and December 2012, there were 151 cooking sessions, with 2,031 people attending (roughly a 50/50 split between adults and children) and many people continuing to use the cooking skills from the course at home.

The longer term, wider impact will be evaluated through monitoring the uptake of free school meals in the target areas and further development of cooking skills, knowledge and confidence within the home and community. This report will be completed in September 2013.



Sexual health in younger people

Anecdotal evidence from service providers appears to show that young people are becoming sexually active at an increasingly young age.

But there is still a wide variation between the types of children we are seeing accessing our sexual health services, from a very distressed 17 year old girl who has had sex for the first time after getting drunk at a party, to a 13 year old girl who has had five different sexual partners over the last few weeks.

Vulnerable and deprived young people are more likely to be sexually active at a younger age and much less likely to access services. They are also much more likely to smoke and take part in risk-taking behaviours. Information and advice offered to young people therefore needs to go beyond sexual health to encompass broader advice and pathways to other services such as smoking cessation.

All NHS sexual health services in Cumbria work in line with the government's 'You're Welcome'^{xxii} criteria with friendly, approachable staff who should have a non-judgemental attitude towards service users, particularly young people.

It has been suggested that many service users, particularly young girls, struggle with low self-esteem, making them particularly vulnerable. Nowadays, we ask patients more questions about partner age, compared with previous years, to help with safeguarding around child exploitation.

Case study:

Smoke-free areas near children

The NHS is always looking to protect children, and Cumbria has seen progress in 2012 in the area of protecting children from the dangers of second-hand smoking.

Cumbria's multi-agency Tobacco Alliance has developed a tobacco control plan and this year held a wide-ranging seminar to guide partner agencies in helping people to stop smoking - particularly around children.

Following the successful 'Take 7 steps out' campaign to persuade parents not to smoke indoors, we are planning to extend our work with young parents. In collaboration with Liverpool University we will be working with children's centres and young parents particularly to identify how best to support the most vulnerable people to give up smoking.

Cumbria has also been working towards the introduction of voluntary agreements to keep children's play areas smoke free. Local authorities have welcomed the opportunity to discuss this initiative and have shown great interest in progressing with voluntary agreements, especially in Allerdale and South Lakes. The number and complexity of responsible authorities within Cumbria is challenging and has resulted in innovative approaches to implementation.

A toolkit will be launched in May 2013 to assist local councils and third sector groups on how to make play areas smoke-free.

Section 4

The future generations

Whilst free condoms are widely available and distributed across a number of community settings, there is still work to be done - sexual health services do not seem to adequately cater for young men, particularly in areas of higher deprivation.

Given the enormous cultural shift towards social media, local NHS services and resources need to play 'catch up' if they are to effectively engage with service users. This is particularly important when it comes to sexual health for young people.

The provision of access to and uptake of effective contraception for young people, particularly those most at risk of teenage pregnancy, is a priority in addressing health inequalities. Increasing effective contraception use results in better outcomes for women and a reduced cost to the health service. Adults should be encouraged to access contraceptive services through primary care to allow more provision of young people's sexual and reproductive health services through multi-agency young people's providers, across all six Cumbrian localities.

Teenage pregnancies

England has the highest rate of conceptions and births amongst younger teenagers in Western Europe. Pregnancy rates among older teenagers have come down sharply in recent years. Although teenage pregnancy does not carry the same stigma as for previous generations, it is associated with a number of negative outcomes, such as lower birth weight and higher infant mortality.

A strategic review of sexual health needs and services undertaken in Cumbria in 2010 showed that 89% of 12-20 year olds felt confident they would know where to go if they were worried about their sexual health; 59% would like to have access to more information about sexual health, particularly through educational talks.

Since the national Teenage Pregnancy Strategy^{xxiii} was launched in 1999, the teenage pregnancy rate among women aged 15-17 in Cumbria has fallen from 41 per 1,000 to 37.4, a reduction of 8.8%. That said, many girls are still having unprotected sex despite having have no wish to become pregnant.

Better education is needed around contraception, particularly in schools. Young people often find information confusing. For example, despite the various types of contraception available, including LARC (long acting reversible contraception), many girls are regularly accessing contraceptive services to request emergency hormonal contraception.

Clinics in Cumbria are really well placed for young people, with many co-located in specific young people's venues. For example, the contraception clinic located at Inspira in Whitehaven opened at the end of August 2012. Of the 176 service users seen since opening, 96 had never accessed sexual health services before.

It is felt that the success of this clinic is largely down to word of mouth and paid-for advertising on social media such as Facebook and Twitter.

Chlamydia

Chlamydia screening has become more normal for young people. This reduced stigma has been observed over a relatively short period of time and screening staff have reported a rapid positive change in attitudes to screening. It is thought this is largely due to increased communications, better education, the use of incentives, and community and outreach screening.

Sexual health in the new public health system

As part of the health reforms taking effect from April 2013, the commissioning responsibilities for sexual health will be transferred from NHS Cumbria to three organisations:

Cumbria County Council will commission comprehensive sexual health services, including:

- Contraception, including LESs (implants) and NESs (intrauterine contraception) – but excluding contraception provided as an additional service under the GP contract.
- STI testing and treatment, including post-exposure prophylaxis after sexual exposure, chlamydia screening as part of the National Chlamydia Screening Programme and HIV testing.
- Sexual health aspects of psychosexual counselling.
- Sexual health specialist services, including young people's sexual health and teenage pregnancy services, outreach, HIV prevention and sexual health promotion work, services in schools, colleges and pharmacies.

Clinical Commissioning Group (CCG) will commission:

- Fully integrated and comprehensive termination of pregnancy services.
- Sterilisation.
- Vasectomy.

NHS Commissioning Board (NCB) will commission:

- Contraception provided as an additional service under the GP contract.
- HIV treatment and care (although work is continuing to determine whether CCGs should commission some elements of the pathway).
- Promotion of opportunistic testing and treatment for Sexually Transmitted Infections and patient requested testing by GPs.

Health promotion and awareness raising are essential to preventing Sexually Transmitted Infections and HIV through improving public awareness and encouraging safer sexual behaviours. A gap that has been identified is a lack of understanding of primary prevention work carried out through the various partner organisations. It is recommended that a primary prevention audit be conducted. And when commissioning services in the future, we should consider a payment by results (PBR) tariff from 2014 onwards.



Cumbria's new health priorities

In my first annual report in 2008, we identified the Five Challenges that had to be taken into consideration when planning local health and wellbeing services. Section 1 of this report examines how well we have done in trying to make progress on these five areas. Here we will examine how these priorities have shifted over the last seven years – and these are the areas that the new health system in Cumbria will be judged on in the future.

Section 5

Cumbria's new health priorities

In November 2012, the Cumbria Health and Wellbeing launched the updated Joint Strategic Needs Assessment^{xxiv} for the county. The JSNA identified four priority areas for health and wellbeing in Cumbria. These priorities and challenges are based around four main themes:

- Inequalities,
- Children & Young People,
- Mental Health & Wellbeing
- Ageing Population

Priority 1 – Inequalities

- **Build a health and social care system based on good intelligence.** The JSNA is an ongoing process. A robust intelligence service, joined up across all public sector organisations and accessible to all, can provide an evidence based system for identifying improvements, establishing options and targeting services that lead to better health and social care systems.
- **Use all available resources.** All public and private organisations must work together to build capacity and improve health and wellbeing. In particular, given that smoking is a major factor in premature mortality and health inequalities, all public, private and 3rd sector organisations should play a part in helping people to stop smoking.
- **Involve our communities and the voluntary sector.** There must be a strong emphasis on public health initiatives, public engagement, self management and a continuation of the commitment to orientate services closer to home to enable our communities to self-manage and be in control of their own health outcomes. There is also a need for more systematic engagement with the voluntary sector, which can be a real engine for innovation
- **Recognise inequalities in all work programmes.** By explicitly recognising the impact that factors such as employment and skills, transport, recruitment, procurement, community engagement, facilities management, economic development and regeneration have on health, the public sector can begin to address inequalities and improve health and wellbeing.

Priority 2 – Children and Young People

- **Ensure children have the best start in life.** Experience, life chances and habits developed in the early years shape health outcomes later in life. Continued support needs to be given to maternal health and maternal behaviours, especially smoking and nutrition before, during and after pregnancy, and nutrition in early years, including breastfeeding.
- **Prioritise lifestyle improvement, particularly around obesity.** Lifestyle and behaviours such as smoking, alcohol and substance misuse in children all have a significant influence on later health outcomes and life chances. In particular, given that obesity is a risk factor for so many diseases, action to reduce childhood obesity will prevent significant ill health in the Cumbrian population in the future, as well as avoiding the financial costs associated with treating conditions linked to obesity.
- **Integrated services and partnership working.** Given the impact of the social and economic determinants on children's health, partnership working between the NHS, local authorities, voluntary sector and other partners is necessary. The effective integration of services for safeguarding children and young people and promoting the mental health and wellbeing of looked after children is of significant importance.
- **Promote mental and emotional wellbeing.** Improving the mental health and wellbeing of young people is crucial to their long-term life prospects.

Priority 3 – Mental Health and Wellbeing

- **Good mental health is more than just the absence of mental illness.** Screening programmes, such as the NHS Health Checks programme, offer an ideal opportunity to emphasise wellbeing and the need for self management. All public sector staff should be encouraged to make “Every Contact Count” by providing information about the ‘Five Ways to Wellbeing’ – connect, be active, take notice, keep learning and give – and help people build them into their everyday lives.
- **Mental health and physical health problems often coexist.** Health and wellbeing would be improved by: increasing access to psychological therapies for people with physical health problems; improving pathways for people with a ‘dual diagnosis’ of mental illness and drug and alcohol problems; and ensuring that people with learning disabilities have access to appropriate information related to their health.
- **Improve services and contain mental health-related costs.** The impact of investment in mental health prevention and continued work to develop mental health services within Cumbria to avoid costly out-of-county placements and to reduce hospital admissions for mental health should improve outcomes and show a cost benefit.

Priority 4 – Ageing Population

- **Increasing numbers of people will live to a greater age with a number of long-term conditions.** Historically, investment in long-term conditions has been on treatment and prevention of further deterioration. Future investment should be focused on preventing or delaying the onset of long-term conditions. People will need to be supported to self-manage their conditions through better patient education and enhanced care pathways, and the current middle-aged population of Cumbria should be encouraged to take greater preventative action (e.g. stopping smoking and adopting healthier lifestyles) to promote healthy ageing and reduce the incidence of long-term conditions.
- **Support communities to remain independent.** As people generally prefer to remain in their own homes as long as possible, developing services to enable them to do this will be particularly important. Developments in telecare, assistive technology, improved housing and personal budgets will be needed to support this, as well as preventative services to reduce risks from problems such as falls and a review into end-of-life care.
- **Many more will suffer from dementia.** Delivery of national and local dementia strategies in partnership with local authorities will be a key issue as the prevalence of dementia increases. Cumbria is going to see growing numbers of people with dementia in addition to other long-term conditions. This will make management far more challenging.
- **Build capacity through partnership working.** An increasingly ageing population will create demand on health and social care services. Mobilising community assets and increasing joined-up working between the NHS, local authorities and voluntary sector will be needed, and further integration across health and social care will be a key issue across all care pathways.

Section 6_

A final word

A final word

In looking back over the six years of the Primary Care Trust, it has been a journey with many challenges and some valuable progress.

It is fair to say that over the six years we have successfully engaged large numbers of people in Cumbria at different levels in gaining an understanding of modern public health and what needs to be done.

We stand on the shoulders of giants and an amazing generation that has bequeathed us the National Health Service. Those who are left of this generation are now over 85 years of age, often frail and in need of high-quality services in their last years. We have a duty of care towards them and the responsibility of stewardship to ensure that the NHS and related public health services continue to be developed in line with that generation's aspirations.

The Latin edict 'Primum non nocere', or 'Above all do no harm', which every medical student learns about, should be a guiding principle. The current health reforms appear to be prejudicing the stability and quality of our NHS legacy.

I chose the theme of 'Those who have served' for this my final report in recognition of the significance of their contribution and the legacy that we must protect.

In many ways the agenda for health protection and improvement in Cumbria has been set and the intelligence is now available to inform what we do. Accompanying this public health report is a separate handy publication containing the county's key health statistics - 'Cumbria in Numbers: 2013'.

However, it has become clear that in public services generally in Cumbria that affect people's health and wellbeing we must do better. I have found in my time here that there is a general consensus that there is a lack of aspiration and ambition for excellence. Often the agencies that must work together are slow to develop an effective and timely approach. The irony is that, when disasters have happened, the multi-agency response has usually been impressive.

In the pursuit of public services fit for the 21st century, good leadership is paramount. The county is rich in assets and the resources of the people of Cumbria can be remarkable. What seems missing at times is the energised leadership for transformation which is necessary if we are to put ourselves on a par with the best in Europe.

Professor John R. Ashton
C.B.E. Director of Public Health and
County Medical Officer for Cumbria
2006 – 2013.

March 2013



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Notes



Professor John Ashton, and
Cockermouth GP John
Howard during the recovery
phase of the 2009 floods
which devastated the town.

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