Cumbria 2012: The Annual Report of the Director of Public Health

Allerdale / Carlisle / Copeland / Eden / Furness / South Lakeland /

Cumbria County Council

NHS Cumbria

Health in Numbers_

- Cumbria is England's second largest county, representing 48% of the land mass in the North West, with an estimated population of 495,000
- 51% of Cumbria's total population live in rural areas. This compares to 19% of the population of England and Wales.
- There are 73 people per Km_2 of Cumbria. Population density is highest in Barrow at 906 people per Km_2 and lowest in Eden at 24 people per Km_2.
- Since 2001 the population of Cumbria has risen by 1.3% compared to a 5.3% rise nationally.
- There were 5,068 live births and 5,431 deaths in Cumbria during 2010
- 31% of working age residents in Cumbria are qualified to NVQ level 4 or higher.
- 49% of people with a disability in Cumbria are employed. This varies from 26% in Copeland to 70% in Allerdale.
- In early 2012 the average house price in Cumbria is £167,455 compared with the national average of £238,205.
- 13% of Cumbrian children live in poverty, which is lower than the national average at 21%.
- There were 1584 deaths from all causes of cancer in 2010. This gives a rate of 319 deaths per 100,000 people.
- Life expectancy in Cumbria is 79.9 years which is slightly lower than the national average.
- In Cumbria 28.5% of people eat five or more portions of fruit and vegetables a day which is similar to the national level.
- 31% of people in Cumbria feel that they can influence decisions affecting their area.
- 85% of adults in Cumbria report that they were satisfied with their local area as a place to live compared to 80% for England as a whole.
- The average household income in Cumbria is £26,004 nearly £3000 less than the national average.
- The number of people unemployed and claiming Job Seekers allowance rose by 238 between January 2012 and February 2012 to reach 9,853 (3.2%). This is the highest it has been since January 2000.
- 13.8% of households in Cumbria have an annual income of less than £10,000
- Out of the 149 counties in England Cumbria is the 85th most deprived. Barrow is the most deprived district in Cumbria while South Lakeland is the least deprived.
- 4.9% of Cumbria's population are from black, minority and ethnic groups compared to 16.7% in England and Wales.
- 258 people were killed or seriously injured on Cumbria's roads during 2010 and 2011.
- In Cumbria there are 9,329 people registered with a learning disability in 2010, this is predicted to increase to 10,074 by 2030.
- In Cumbria there were around 7,000 people with Dementia, by 2030 this is estimated to increase to around 13,000.

Contents_

Foreword_

Following the devastating events that have touched Cumbria in recent years, my 2011 report focused on resilience and the steps that the public, professionals, health services and partners can take to prepare, protect, prevent and respond to hazards and threats to health. The report explored the role of vaccine and screening programmes, our performance at tackling infection and infection prevention, emergency planning and our emergency response to major incidents as well as an overview of the counties hazardous occupations and injury and violence statistics. By bringing together an overview of our resilience, response and health protection strategies, I expressed the hope that we would be in a stronger position to reduce the toll of avoidable ill health in the coming years.

This is my fifth annual report on the health of the people of Cumbria.

The introduction of Public Health Annual Reports extends back over 150 years to the first reports produced by the Medical Officers of Health in local government. Those reports represented the independent assessment of the state of health in boroughs around the country and were presented to the annual meeting of the borough council. Their independence from political interference was guaranteed and the right of the Medical Officer of Health to draw attention to uncomfortable facts was protected. Medical Officers of Health could not be removed from office for being controversial, only for incompetence.

As I draft this year's annual report, on the cusp of public health functions in England being returned from the National Health Service to a partial base in local government, it is important that we should remind ourselves of the influence of these important documents of record.

For my report this year, I have chosen to focus on some broad areas of public health as we begin to develop the new public health system. I will provide an overview of the health characteristics of each of our six localities within Cumbria, including the challenges that each locality is facing, I will then describe some key public health topics that affect people at different stages of the life cycle:

- Adolescence and epilepsy
- Working age adults and the impact of the economic recession
- Older adults and sensory loss
- The health of military veterans.

I then review progress made on recommendations made in last year's report.

Dr John R Ashton CBE
Director of Public Health
& County Medical Officer, Cumbria

Introduction_

The last 18 months has been a time of turmoil and tension within the National Health Service, not least for public health, as the coalition government's intentions for health and social care and public health have become clearer, culminating in the recent passage of the Health and Social Care Bill. It has become clear that the structure and arrangements for all these fundamental aspects of our daily lives are to be subject to more radical change than at any time since the creation of the National Health Service in 1948.

Taking the long view, we can see that the origins of public health in the 1840s were grounded in the immense threat to health posed by rapid urbanisation, slum dwellings, squalor and epidemic disease. In response, the town councils of the day, in varying degree, took up the gauntlet and developed a public health system based on local government, which was to be copied around the world, not least in those countries that today are part of the British Commonwealth. The emphasis of these early efforts was initially on the separation of human and animal waste from food and water, ensuring sound basic provision of shelter, the paving of the streets and removal of refuse.

In the years following the 1848 Public Health Act, the credibility of Local Authorities was built on their ability to create environmental and social conditions conducive to the protection of the health of the poorest and creating the conditions in which trade and business could flourish. Over time, this credibility enabled Local Authorities to extend their reach into a wide range of services and activities including such matters as municipal housing, parks and gardens, wash houses and swimming pools, schools, social services, municipal gas works, tramways and many other endeavours which became synonymous with the concept of local government.

Today, many have forgotten that the early pioneering work of local government lay in the mobilising of the public and of the assets of the town through an alliance of business, church, community leaders and early public health pioneers, and that the development of specialist services was secondary to that corporate, visionary leadership.

By the end of the Second World War, many believed that public health had completed its task in local government, with the coming of antibiotics and vaccines and improved social conditions that had led to the apparent disappearance of terrifying scourges like tuberculosis and childhood diseases such as whooping cough, diphtheria and polio, which had affected large number of infants well into the 1930s. The future was felt to be with technology, pharmaceuticals and specialist medical care. Family medicine increasingly took second place to hospitals, and public health services withered until in 1974 the post of Medical Officer of Health was abolished and replaced by community physicians in Health Authorities. The sometimes huge public health directorates were split up to create new directorates such as social services and environmental health. Many of the front line health workers such as Health Visitors and Community Nurses, together with the clinics from which they operated, were dispatched on a nomadic journey around the clinical world of the National Health Service. Humpty Dumpty certainly fell of the wall in 1974 and the silos that were created in place soon came to be seen to have limitations.

For the past 38 years there has been debate and growing consensus of the need to reintegrate front line health and social care closer to home and away from specialist institutional settings, coupled with a recognition that securing future improvements in health and wellbeing, and protecting the health of an increasingly ageing population, requires a whole system approach in which the organised efforts of society can pull together to create the conditions under which people can thrive, realise their potential and enjoy a long and full life.

The demographic challenge, coupled with increasing possibilities for technical intervention based on science and an evidence base, have been joined by the recent global economic crisis to create a perfect storm in which rising public expectations have proven to be the straw that could potentially break the camel's back.

Successive governments have struggled to articulate a way forward which remains true to the founding principles of the National Health Service; that there should be equal access to health services to everybody, irrespective of wealth or social position, and that it should be free at the time of use.

Here in Cumbria, five years ago we set out to reconfigure health services closer to home, based on a public health model of optimising health for the whole population through prevention as well as treatment and care. Our model has seen more people treated in the community and being given the support to be experts in their own health.

We have made significant progress in re-orientating the health service in the county towards a local system led by primary care, based on public health principles and with increasingly strong partnerships at every level.

The recent government reforms have resulted in a loss of momentum which must now be restored if we are to square the circle of the increasing demands at a time of diminished resources.

The large scale structural changes in the National Health Service and the changing relationships between the health service and Local Government and other agencies is a matter of great concern to me, from the point of view of increasing risks, not least those involving the safeguarding of children and adults. Other areas of concern include the future of the robust systems that we have been putting in place for reporting on and learning from serious untoward incidents, the commissioning of reviews into matters of concern such as perinatal mortality and related services and the ability to intervene in matters of serious service failure such has occurred with the breast screening services in North Cumbria.

Transforming Public Health

Since the launch of the NHS White Paper 'Equity and excellence: liberating the NHS', in April 2010, there has been much debate about the future of the health service and the direction of public health. This led to many changes to the Bill, which took a protracted path through parliament.

Now that the Health and Social Care Bill has passed through parliament, and the structural changes will come into place on the 1st April 2013, the public health service will return at least in part to the Local Authority home which it left in 1974.

The thinking behind this is that public health, when based in local government, should have the opportunity to act as a catalyst for change across the wide range of functions that make up local government. Health in all policies is a key theme, building on the assets and social capital of the community. The intention is to seek holistic solutions to health and wellbeing which embrace the public and private sectors and all of the partners who have a contribution to make to health and wellbeing. We must revisit the contribution from town planning, education, housing, transport, employment, the environment and those factors which build social

capital and resilience in ensuring that we have a unified approach to improving health.
In reality, even in 1948 it was never the case that public health was seen as completely separate from the National Health Service, whose inaugural structure was described as tripartite. The hospitals, under the direction of hospital boards, stood side by side with family doctors and other community health services (opticians, pharmacies, dentists) and the third arm of the health service was public health departments in the town hall.

Today, what we are about to see is a new version of the tripartite structure, in which the local Director of Public Health will need to straddle the three parts of the public health functions which will be found in Local Authorities, Public Health England and the clinical work of the National Health Service, especially as it relates to General Practice led commissioning of health and social care. Central to this new set of arrangements will be the integrative role of Health and Wellbeing Boards.

What are health and wellbeing boards?

Health and wellbeing boards will be established as a 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.

Each top tier and unitary authority will have its own Health and Wellbeing Board. Board members will work together to understand the needs of their local community, agree priorities to improve health and wellbeing and encourage the development of more integrated commissioning of services across health and social care. As a result, patients and the public should experience more joined-up services from the NHS and local councils in the future. The boards will also help give communities a greater say in understanding and addressing their local health and social care needs.

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

- one local elected representative
- a representative of 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.

Since April 2012, Health and Wellbeing Boards have been established in shadow form. Boards will take on their statutory functions from April 2013. They will have a duty to involve local people in preparation of key documents, such as the Joint Strategic Needs Assessments, and the development of joint Health and Wellbeing Strategies and decision making.

In Cumbria, the Board of Health and Wellbeing 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 with regard to approaches to drugs and alcohol, and injury and violence prevention. The election of the Police and Crime Commissioner in November this year will raise the profile of action on these matters. Taken together, these different partnership bodies represent a 21st Century reinvigoration of public service administration and public engagement.

As well as changes to the structure and management of health service support systems, the reforms point towards a larger role for the private sector in the delivery of treatment and care. This is not new for the National Health Service, with some private firms already undertaking some NHS work especially in surgical areas and there are also some services such as such as specialist mental health support being provided by the independent sector.

Currently around £1 out of every £20 spent nationally goes to non-NHS providers, yet the proposed reforms are likely to open this much wider. This has proved extremely controversial and exposed the government to claims that the ultimate aim is the privatisation of health care based on private health insurance. If this does turn out to be the case, the experience from other countries is that cost containment of health services will become much more problematic and there is likely to be a significant increase in administrative costs, an effective levy of the health budget through the need to pay profits to shareholders and increased inefficiencies through duplication of services. Experience shows that the private sector is interested in some parts of medical care which are readily profitable such as certain surgical specialities but avoids others such as obstetrics, traumas care, mental health and geriatrics where costs are must less predictable in relation to need.

It has also been assumed that the introduction of more private providers into health care provision is essentially benign, yet we must not forget the behaviour of many private cosmetic clinics who have turned their backs on their responsibility to provide aftercare to their patients following the breast implant safety scare of December 2011. Clinicians, whether based in the community or in hospital, have important opportunities to contribute to public health, as our experience in Cumbria over the past five years has demonstrated. We need to build on this through our local GP Consortia in the years ahead.

'Equity and excellence: liberating the NHS' states that "the vision builds on the core values and principles of the NHS - a comprehensive service, available to all, free at the point of use, based on need, not ability to pay". As the changes to health and social policy progress, it remains to be seen if this will prove accurate.

Section 1_

District profiles:

The demographic and health inequality challenges

Having a good understanding of the people of Cumbria, their wellbeing, lifestyles and health needs, as well as their use of health and social care and trends in disease and illness rates is vital to help to plan and target services appropriately, tackle inequalities and fulfil the health and wellbeing needs of the people of Cumbria, including those of vulnerable and hard to reach groups.

This section looks at each of the six localities within Cumbria (Carlisle, Allerdale, Copeland, Eden, Furness and South Lakeland), giving an overview of health and demographic statistics, and case studies on initiatives to improve health in each area.

The Cumbria Joint Strategic Needs Assessment (JSNA) provides a more in-depth strategic overview of the needs of the people in Cumbria. The JSNA is the basis for the Health and Wellbeing Strategy. Reviewed annually, the JSNA will, overtime, develop to include an enhanced focus on the human and physical assets for health – other than just financial – which will have to be mobilised to optimise wellbeing in the world we now find ourselves.

Carlisle_

Domain	Measure
Social and Place Wellbeing	1. % working age adults with level 4 or greater education
	2. Fuel poverty
	3. Excess winter deaths
	4. All benefit claimants
	5. % children living in poverty
	6. % who feel that they belong to their immediate neighbourhood
	7. % people who agree they can influence decisions in their area
Lifestyles and Health Improvements	8. Estimated smoking prevalence
	9. % of mothers smoking during pregnancy
	10. Hospital admissions due to alcohol (per 100,000)
	11. % reporting drunk and rowdy behaviour as a problem
	12. Estimated prevalence of drug misuse (crack and opiates) per 1000
	13. % of physically active adults (30 minutes, 5 times a week)
	14. % children participating in PE (3 hours of PE a week)
	15. % Healthy eating among adults (5 portions of fruit and veg a day)
	16. % of year six children obese
Health and Wellbeing Status	17. Mortality from all cancers <75 (per 100,000)
	18. Mortality from all circulatory disease <75 (per 100,000)
	19. Hospital admissions for neuroses (per 100,000)
	20. Admissions for deliberate self-harm (per 100,000)
	21. Mortality from suicide and injuries undetermined (per 100,000)
	22. Infant mortality per 1000 births
	23. % born with low birth weight (<2.5kg)
	24. Teenage pregnancy rate (aged 15-17) per 1000
	25. % working age population with a disability
	26. % working age adults with disabilities in employment
	27. % of 0-15 entitled to disability living allowance
Service Utilisation	Hospital emergency admissions per 1000 of the publication
	Calls to CHOC (Cumbria Health on Call) per 1000 of the population
	Calls to ambulance service per 1000 of the population
	Adult Social Care Service users per 1000 pop aged 18+
	Adults predicted to have Dementia per 1000 of the pop aged 18+
	Number of cared for known to ASC per 1000 of the pop aged 18+
	Children's Social Care Service users per 1000 pop aged 0-17

_Statistical Summary of **Carlisle**

		Trend	Comparisons		
	Carlisle	Compared to previous data	Cumbria	North West	England
	28%	Improving	30.9%	28.7%	31.3%
	24.7%	Deteriorating	28.1%	22.1%	18.4%
	19.2%	Deteriorating	17	17.6	18.1
	14.6%	Similar to	13.8	18	14.4
	16.9%	Similar to	15.4%	23.1%	21.3%
	63%	Similar to	70%	no data	59%
	41%	Improving	39.7%	no data	29%
	25%	no data	21.5	23.4	21.2
	15.2%	no data	15.3	no data	no data
	2,022	Deteriorating	1896	2295	1743
	20%	Improving	20%	no data	no data
	9.2	Similar to	7.5	11.5	9.4
	14%	Improving	14.7%	11.2%	11.7%
	56.7%	no data	59.8%	57.9%	55.1%
	28.1%	Improving	28.5%	26.2%	28.7%
	20.3%	Similar to	20.8%	19.7%	19%
	123	Similar to	111	123	110
	77	Improving	72	86	70
	19.8	Deteriorating	18.8	30.1	16.4
	309.7	no data	234.5	263.2	198.3
	10.5	Improving	9.1	9	7.9
	2.7	Deteriorating	3.4	4.9	4.6
	6.6%	Improving	6.8%	7.2%	7.3%
	52.7	Similar to	37.4	43.5	38.1
	15.7%	Improving	20.6%	22.5%	20.5%
	42.9%	Improving	49.3%	44%	49.2%
	2.3%	Similar to	2.6%	2.9%	2.8%

	Per pop	Actual
	115	12,578
	292	31,965
	109	11,941
	44	3,679
	17	1,395
	49	4,122
	27	541

KEY	
	= Worse than
	= Similar to
	= Better than

*Note: The colours denote Carlisle's comparative performance against Cumbria, the North West Region and England.

The district of Carlisle is in the north east corner of the county. The historic city of Carlisle is the largest in Cumbria and acts as service centre and transportation hub for the north of the county and the south west of Scotland. The district includes the market towns of Brampton, Dalston and Longtown. Carlisle district contains two Areas of Outstanding Natural Beauty and the western part of Hadrian's Wall which is classified as a World Heritage Site by UNESCO.

Carlisle is the most populated district in Cumbria with a current population of 104,500 people and a geographical area of 1,040 km^2. While primarily urban, the district still contains notable rural areas with 29.5% of residents in Carlisle district living in rural areas. This rurality can have a significant impact on some residents' ability to access essential services including schools, post offices, and GPs. A Lower Super Output Area in Lyne ward is the 18th most deprived ward in England in terms of geographical barriers to services.

The story of health and wellbeing in Carlisle district is mixed.

Carlisle district has the lowest proportion of households living in fuel poverty yet has a high rate of excess winter deaths.

Negative lifestyle choices and behaviours have heightened health inequalities within the district. Levels of smoking, alcohol related harm and serious drug misuse are high while rates of participation in physical activity are amongst the lowest in the county.

The impact of major diseases on the residents of Carlisle district is high. The district has the highest premature mortality rate from cancer in Cumbria and a mortality rate from circulatory disease above the county average.

There are significant issues relating to the health of children and young people in the district with evidence of risk taking behaviour. The rate of teenage pregnancy is the highest in the county. Carlisle district also has some of the highest rates of alcohol related harm among children and young people in England and a high number of hospital admissions for deliberate self harm.

In terms of infant health the picture is positive. Carlisle district has the second lowest rate of infant mortality in the county and a lower percentage of babies born with a low birth weight than the county and national average.

The district has the lowest percentage of working age adults with a disability in Cumbria.

The district's overall performance in a range of health and wellbeing indicators disguises significant inequalities in health outcomes with a 9.7 year gap between the highest and lowest life expectancies in Carlisle district.

Carlisle: A Healthy City

In 2009 Carlisle was designated a World Health Organisation Healthy City. The programme has three key themes: caring and supportive environments, healthy living and healthy urban planning and design.

The first Carlisle Healthy City week took place from 17th – 23rd October 2011 and was an opportunity to involve a wide range of agencies and individuals in celebrating the Healthy City work. It also provided a focus for developing the Healthy City work with key partners and to encourage individuals and families from across the district to participate in a range of activities designed to promote healthy living.

During the week local leisure providers opened their doors to offer substantially discounted or free sessions including outdoor gym sessions and exercise to music classes. There was also an opportunity to visit the 'Fit to Grow' allotment projects, which was followed by a cooking demonstration. The Youth Zone in Carlisle also supported the event by consulting with young people and developing their own Health Manifesto.

During the week there were a series of core events including 'Get into Reading', 'Growing a Healthy Carlisle', 'Preventing Young People Smoking' and a healthy urban planning

conference. These events aimed to bring together key stakeholders and individuals such as elected members and GPs to discuss opportunities to improve collaboration between partners and to progress Carlisle's Healthy City agenda.

For more information about Carlisle Healthy City, visit **www.carlisle.gov.uk**.

Lung Cancer Awareness Campaign

Carlisle GPs supported the 'Cough, Cough' campaign which was designed to raise awareness of lung cancer signs and symptoms. One key aim of the campaign was to encourage people to see their GP if they had had a cough for more than three weeks. During the campaign those presenting with a cough increased by 61% in the target areas. Campaign materials featuring real Cumbrian people who've been diagnosed with lung cancer were distributed widely across the district and this included door drops in targeted areas and using bus shelters, and bus sides to promote the campaign message.

Lung cancer is one of the biggest cancer killers and in 2007, the latest year for which figures are available, 321 people in Cumbria died from the disease.

The earlier someone is diagnosed with lung cancer, the better their chances of treatment and survival. Symptoms of lung cancer include:

- persistent coughing for several weeks
- unexplained weight loss
- shortness of breath
- chest pain
- blood in phlegm.

Allerdale_

Domain	Measure
Social and Place Wellbeing	1. % working age adults with level 4 or greater education
	2. Fuel poverty
	3. Excess winter deaths
	4. All benefit claimants
	5. % children living in poverty
	6. % who feel that they belong to their immediate neighbourhood
	7. % people who agree they can influence decisions in their area
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	20. Admissions for deliberate self-harm (per 100,000)
	21. Mortality from suicide and injuries undetermined (per 100,000)
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	Adult Social Care Service users per 1000 pop aged 18+
	Adults predicted to have Dementia per 1000 of the pop aged 18+
	Number of cared for known to ASC per 1000 of the pop aged 18+
	Children's Social Care Service users per 1000 pop aged 0-17

_Statistical Summary of **Allerdale**

		Trend	Comparisons		
	Allerdale	Compared to previous data	Cumbria	North West	England
	30.2%	Improving	30.9%	28.7%	31.3%
	27.7%	Deteriorating	28.1%	22.1%	18.4%
	15.4%	Improving	17	17.6	18.1
	14.9%	Similar to	13.8	18	14.4
	16.5%	Similar to	15.4%	23.1%	21.3%
	76%	Improving	70%	no data	59%
	40%	Improving	39.7%	no data	29%
	22.2%	no data	21.5	23.4	21.2
	13.7%	no data	15.3	no data	no data
	1,957	Similar to	1896	2295	1743
	18%	Improving	20%	no data	no data
	7.2	Deteriorating	7.5	11.5	9.4
	14.2%	Similar to	14.7%	11.2%	11.7%
	60.3%	no data	59.8%	57.9%	55.1%
	27.2%	Improving	28.5%	26.2%	28.7%
	21.7%	Deteriorating	20.8%	19.7%	19%
	120	Similar to	111	123	110
	75	Similar to	72	86	70
	15.8	Deteriorating	18.8	30.1	16.4
	175.9	no data	234.5	263.2	198.3
	12.4	Deteriorating	9.1	9	7.9
	3	Improving	3.4	4.9	4.6
	6.8%	Deteriorating	6.8%	7.2%	7.3%
	42.9	Deteriorating	37.4	43.5	38.1
	18.5%	Deteriorating	20.6%	22.5%	20.5%
	69.7%	Improving	49.3%	44%	49.2%
	2.5%	Deteriorating	2.6%	2.9%	2.8%

	Per pop	Actual
	110	10,913
	226	22,355
	99	9,780
	45	3,161
	19	1,336
	35	2,401
	24	464

KEY	
	= Worse than
	= Similar to
	= Better than

*Note: The colours denote Allerdale's comparative performance against Cumbria, the North West Region and England.

The district of Allerdale is in West Cumbria. Allerdale includes the Solway Coast Area of Natural Beauty, northern parts of the Lake District National Park including the tourist centre of Keswick, and the West Coast urban centres of Workington and Maryport. Other major towns in the district include the historic Cockermouth, the market town of Wigton and the seaside resort of Silloth.

Allerdale is the third most populated district in Cumbria with a current population of 94,100 people and a geographical area of 1,242 km^2. Despite notable urban centres, 69% of Allerdale's population live in rural areas. Allerdale's rural nature has a significant impact on some residents' ability to access essential services including schools, post offices, and GPs. A Lower Super Output Area in Crummock ward in Allerdale is the 9th most deprived in England in terms of geographical barriers to services.

Suicide is a significant and increasing issue in Allerdale. The district has the highest mortality rate from suicide and injuries undetermined in Cumbria.

There are significant issues relating to the health of children and young people in Allerdale with evidence of risk taking behaviour. The rate of teenage pregnancies in Allerdale is rising and is the second highest in Cumbria. The district has the fourth highest rate of alcohol related harm among children and young people in England. The percentage of year 6 children classified as obese is above county average and rising.

Allerdale has the second lowest percentage of disabled adults in Cumbria and the highest rate of those with a disability that are currently in employment.

The district's overall performance in a range of health and wellbeing indicators disguises significant inequalities in health outcomes. Within Allerdale there is a 12.4 year gap between the highest and lowest life expectancies, with life expectancies in some areas 8.4 years lower than the national average.

The ageing nature of Allerdale's population presents significant health challenges for the district in terms of future demand on health and social care services

Sexual Health Services

Allerdale was the first locality to provide sexual and reproductive health service at a local level for patients who are symptomatic as well as asymptomatic. Maryport and Keswick practices have been the pathfinders in this development and have supported other practices across Cumbria in the delivery of sexual health services in the community.

Anyone requiring sexual health advice, treatment or testing can now ring **Sexual Healthline Cumbria** to be directed to the nearest local service.

Asset Based Community Development (ABCD) Community Regeneration

An asset based community development (ABCD) programme has been explored in Northside in partnership with Derwent and Solway Housing Association, The Big Life Company and the Residents Association.

On 19th November 2009, following a long spell of wet weather, there were major floods affecting several parts of Cumbria, wiping out local medical services for over 15,000 people in Cockermouth, as well as cutting off services for a whole community in Workington. Other towns including Keswick, Kendal, Ulverston, Egremont and Crosby-on-Eden were also affected.

NHS Cumbria worked closely with the police and Local Authorities to ensure a swift response to the Cumbria floods, quickly re-establishing services and identifying at risk patients.

The immediate response from a wide range of agencies was impressive, with a temporary footbridge and railway station being erected within weeks of the disaster. However, what was even more impressive was the response from the local community. They demonstrated the capacity and ability to do things differently when the previously taken for granted services such as GPs, banking and shopping were no longer readily available.

The community response led to the consideration of developing an Asset Based Community Development (ABCD) approach, considering local assets as the primary building blocks of sustainable community development. The aim was to build on the skills of local residents, the power of local associations, and the supportive functions of local institutions towards a new and more sustainable future for Northside.

In establishing the project, the project team have taken inspiration from examples of other community regeneration projects such as the Kath Locke Centre in Manchester, which focused on partnership working to address the issues of deprivation.

It is hoped that a shift towards asset based community development in Northside can help to build on community involvement work delivered to date and help build a lasting legacy from the floods.

The main objectives of the Community Development work are:

- To help the people of Northside identify and build on the skills and abilities available in the area.
- Develop a holistic approach to wellbeing in Northside.
- Empower local people to take control of their own health and wellbeing.
- To create a hub at the heart of the local community that is accessible to local people which helps to deliver services appropriate to their needs.

Working with local people, a steering group has been established to review the operation and services delivered through the existing Northside Community centre and help to steer its future direction as a hub for the local community.

Exercise on Referral Programme

Allerdale Locality has recently commissioned a new exercise on referral scheme which is provided by Carlisle Leisure Ltd. The scheme helps patients who have medical problems but struggle to start being active. This scheme is available across Wigton, Maryport, Keswick, Cockermouth and Workington.

Exercise on referral schemes are designed to help people with conditions such as type 2 diabetes, stroke and coronary heart disease. They provide support to help people become more active to improve their health. Patients are referred to the scheme by their GP onto a 12 week programme to help them develop their activity levels to improve their health in the longer term and give them tips to carry on being more active.

Dr Fayyaz Chaudhri is the Lead Commissioning GP for Allerdale. He said: "This service is all about providing that little bit extra support to people who struggle to be active, but whose long-term health would benefit from some short term support to help them on the road to a more active lifestyle. We already know that this form of programme supports people in this type of situation by providing professional knowledge, to help boost confidence and also help people plan realistic targets which they can aim for to continue with after their programme ends."

It is hoped the long-term outcomes will be that patients participating on this programme will take more responsibility for their own physical fitness in relation to their health, that it will reduce the number of admissions to hospital for chronic illnesses and reduce the number of repeat admissions for cardiac and pulmonary episodes.

Copeland_

Domain	Measure
Social and Place Wellbeing	1. % working age adults with level 4 or greater education
	2. Fuel poverty
	3. Excess winter deaths
	4. All benefit claimants
	5. % children living in poverty
	6. % who feel that they belong to their immediate neighbourhood
	7. % people who agree they can influence decisions in their area
Lifestyles and Health Improvements	8. Estimated smoking prevalence
	9. % of mothers smoking during pregnancy
	10. Hospital admissions due to alcohol (per 100,000)
	11. % reporting drunk and rowdy behaviour as a problem
	12. Estimated prevalence of drug misuse (crack and opiates) per 1000
	13. % of physically active adults (30 minutes, 5 times a week)
	14. % children participating in PE (3 hours of PE a week)
	15. % Healthy eating among adults (5 portions of fruit and veg a day)
	16. % of year six children obese
Health and Wellbeing Status	17. Mortality from all cancers <75 (per 100,000)
	18. Mortality from all circulatory disease <75 (per 100,000)
	19. Hospital admissions for neuroses (per 100,000)
	20. Admissions for deliberate self-harm (per 100,000)
	21. Mortality from suicide and injuries undetermined (per 100,000)
	22. Infant mortality per 1000 births
	23. % born with low birth weight (<2.5kg)
	24. Teenage pregnancy rate (aged 15-17) per 1000
	25. % working age population with a disability
	26. % working age adults with disabilities in employment
	27. % of 0-15 entitled to disability living allowance
Service Utilisation	Hospital emergency admissions per 1000 of the publication
	Calls to CHOC (Cumbria Health on Call) per 1000 of the population
	Calls to ambulance service per 1000 of the population
	Adult Social Care Service users per 1000 pop aged 18+
	Adults predicted to have Dementia per 1000 of the pop aged 18+
	Number of cared for known to ASC per 1000 of the pop aged 18+
	Children's Social Care Service users per 1000 pop aged 0-17

_Statistical Summary of **Copeland**

		Trend	Comparisons		
	Copeland	Compared to previous data	Cumbria	North West	England
	19.2%	Deteriorating	30.9%	28.7%	31.3%
	25.5%	Deteriorating	28.1%	22.1%	18.4%
	23.9%	Similar to	17	17.6	18.1
	16.9%	Similar to	13.8	18	14.4
	17.8%	Improving	15.4%	23.1%	21.3%
	67%	Similar to	70%	no data	59%
	36%	Improving	39.7%	no data	29%
	22%	no data	21.5	23.4	21.2
	14.2%	no data	15.3	no data	no data
	2,121	Similar to	1896	2295	1743
	30%	Improving	20%	no data	no data
	6.1	Improving	7.5	11.5	9.4
	16.7%	Improving	14.7%	11.2%	11.7%
	54.5%	no data	59.8%	57.9%	55.1%
	26.6%	Improving	28.5%	26.2%	28.7%
	23.9%	Deteriorating	20.8%	19.7%	19%
	115	Improving	111	123	110
	83	Improving	72	86	70
	15.5	Similar to	19	30.1	16.4
	259.0	no data	234.5	263.2	198.3
	8.2	Improving	9.1	9	7.9
	4.5	Deteriorating	3.4	4.9	4.6
	8.4%	Deteriorating	6.8%	7.2%	7.3%
	38.2	Improving	37.4	43.5	38.1
	21.8%	Deteriorating	20.6%	22.5%	20.5%
	26.3%	Deteriorating	49.3%	44%	49.2%
	2.9%	Similar to	2.6%	2.9%	2.8%

	Per pop	Actual
	125	8,887
	301	21,471
	101	7,182
	36	2,020
	15	859
	35	1,983
	30	403

KEY	
	= Worse than
	= Similar to
	= Better than

*Note: The colours denote Copeland's comparative performance against Cumbria, the North West Region and England.

The district of Copeland is in West Cumbria. The administrative centre is the coastal town of Whitehaven. The other towns in Copeland are Egremont and Cleator Moor in the north of the district and Millom in the south. Copeland has a rich natural landscape, including 56 miles of coastline. Two thirds of the district falls into the western Lake District National Park an area that includes England's highest mountain Scafell Pike.

Copeland is the second least populated district in Cumbria after Eden with a current population of 69,500 people and a geographical area of 732 km^2. Despite notable urban centres, 59.2% of Copeland's population live in rural areas. The district's rural nature has a significant impact on some residents' ability to access essential services including schools, post offices, and GPs. A Lower Super Output Area in Seascale ward in the south of Copeland is the 14th most deprived ward in England in terms of geographical barriers to services.

Copeland has relatively low levels of social and place wellbeing. The district has the lowest levels of education attainment in the county and high levels of unemployment. Levels of perceived influence in decision making are also the lowest in Cumbria.

There are significant issues with alcohol misuse in Copeland, including some of the highest rates of alcohol related harm among children and young people in England.

There is evidence of unhealthy lifestyles among children and young people in the district. Copeland has the lowest proportion of children participating in quality PE in Cumbria and the highest levels of childhood obesity in the county.

While the impact of major diseases on the residents of Copeland has lessened over time, the mortality rate from both cancer and circulatory disease are both above the county and national average.

The picture is also negative and deteriorating in terms of infant health. Copeland has the highest rate of babies born with a low birth weight in Cumbria and the second highest rate of infant mortality in the county.

The district has the lowest proportion of disabled adults in employment in Cumbria at nearly half the county average. The number of disabled people overall is above the county average and rising.

Copeland Public Health Quality and Outcomes Framework

The Copeland Public Health Quality and Outcomes Framework is a locality extension of the national Quality and Outcomes Framework, developed in partnership with Public Health Cumbria, Cumbria PRIMIS and the Copeland locality. It is a primary care quality improvement initiative that aims to address key areas of health inequality in the locality and focus upon the priorities set out in the Copeland Strategic Plan.

The indictors were developed to increase the public health role of GPs and improve health outcomes for patients. The indicators have covered areas such as increasing long acting reversible contraception, addressing alcohol consumption, obesity, smoking and hard to reach groups. This has helped provide us with a comprehensive picture of the health of people within Copeland. As a result the locality has been able to put in place an Exercise Rehabilitation programme and one study showing that of those in the hard to reach groups who attended the practice 40% needed preventative treatment to avoid sudden or chronic health issues later in life.

Fit4Me

The Copeland 'Fit4Me' programme for young people was developed out of a need for young people in Copeland to have access to a regular programme of physical activity that was enjoyable and low impact. A steering group with representatives from NHS Cumbria, Copeland Borough Council, Connexions Cumbria and North Country Leisure worked together to develop a programme that met the needs and expectations of the young people involved.

It was decided that a programme based around self esteem and confidence building would be more appropriate than trying to develop a weight loss programme. The main measure of success was for young people to attend regularly and enjoy participating in new forms of exercise.

North Country Leisure and Connexions Cumbria were instrumental in the delivery of the sessions and the transport of the young people to and from the venue. The tutors and co-workers remained the same throughout the programme allowing the young people to develop relationships and feel more comfortable and express themselves during the sessions.

At the beginning of the programme the young people were asked to complete an emotions questionnaire rating themselves on a 1-10 score chart which focused on how they felt about themselves, what their confidence was like. This was repeated at the end of the programme and showed a marked improvement with the young people scoring themselves on average 34 points higher than they had at the beginning of the programme.

Referrals were an area of concern and work is still on going to try and ensure that the correct procedures are followed during the referral process into the scheme. The programme is aimed at young people who are overweight. The steering group feels that it is essential that the first point of contact with the young people and their families comes from a medical professional who can explain why the Fit4Me programme would be beneficial. Another area that the group are working on is to engage with parents and guardians to try and deliver some educational sessions as part of the programme that will target both the young people and also educate parents on healthy foods and lifestyle choices to support their child.

More and more Cumbrian parents protect their children from measles, mumps and rubella

Over 95% of parents in Cumbria are taking the opportunity to protect their children from measles, mumps and rubella by taking them to have the MMR vaccine, some of the highest rates in the country.

Children are invited to get their first MMR vaccination at around 13 months of age, when the immunity the baby got from its mother begins to fade. They are then given a booster dose before they start school.

Measles, mumps and rubella are highly infectious, common conditions that can have serious health complications, such as meningitis, swelling of the brain (encephalitis) and deafness. Cumbria's excellent vaccine rates are helping protect our residents against illness.

Eden_

Domain	Measure
Social and Place Wellbeing	1. % working age adults with level 4 or greater education
	2. Fuel poverty
	3. Excess winter deaths
	4. All benefit claimants
	5. % children living in poverty
	6. % who feel that they belong to their immediate neighbourhood
	7. % people who agree they can influence decisions in their area
Lifestyles and Health Improvements	8. Estimated smoking prevalence
	9. % of mothers smoking during pregnancy
	10. Hospital admissions due to alcohol (per 100,000)
	11. % reporting drunk and rowdy behaviour as a problem
	12. Estimated prevalence of drug misuse (crack and opiates) per 1000
	13. % of physically active adults (30 minutes, 5 times a week)
	14. % children participating in PE (3 hours of PE a week)
	15. % Healthy eating among adults (5 portions of fruit and veg a day)
	16. % of year six children obese
Health and Wellbeing Status	17. Mortality from all cancers <75 (per 100,000)
	18. Mortality from all circulatory disease <75 (per 100,000)
	19. Hospital admissions for neuroses (per 100,000)
	20. Admissions for deliberate self-harm (per 100,000)
	21. Mortality from suicide and injuries undetermined (per 100,000)
	22. Infant mortality per 1000 births
	23. % born with low birth weight (<2.5kg)
	24. Teenage pregnancy rate (aged 15-17) per 1000
	25. % working age population with a disability
	26. % working age adults with disabilities in employment
	27. % of 0-15 entitled to disability living allowance
Service Utilisation	Hospital emergency admissions per 1000 of the publication
	Calls to CHOC (Cumbria Health on Call) per 1000 of the population
	Calls to ambulance service per 1000 of the population
	Adult Social Care Service users per 1000 pop aged 18+
	Adults predicted to have Dementia per 1000 of the pop aged 18+
	Number of cared for known to ASC per 1000 of the pop aged 18+
	Children's Social Care Service users per 1000 pop aged 0-17

_Statistical Summary of **Eden**

		Trend	Comparisons		
	Eden	Compared to previous data	Cumbria	North West	England
	32.6%	Deteriorating	30.9%	28.7%	31.3%
	38.3%	Deteriorating	28.1%	22.1%	18.4%
	14.7%	Deteriorating	17	17.6	18.1
	8.2%	Similar to	13.8	18	14.4
	9.2%	Similar to	15.4%	23.1%	21.3%
	77%	Similar to	70%	no data	59%
	38%	Improving	39.7%	no data	29%
	17.9%	no data	21.5	23.4	21.2
	13.5%	no data	15.3	no data	no data
	1,367	Deteriorating	1896	2295	1743
	14%	Improving	20%	no data	no data
	6	Improving	7.5	11.5	9.4
	17.1%	Improving	14.7%	11.2%	11.7%
	60.6%	no data	59.8%	57.9%	55.1%
	31.7%	Improving	28.5%	26.2%	28.7%
	23%	Deteriorating	20.8%	19.7%	19%
	94	Deteriorating	111	123	110
	59	Improving	72	86	70
	19.1	no data	19	30.1	16.4
	110.3	no data	234.5	263.2	198.3
	8.7	Deteriorating	9.1	9	7.9
	2.1	Improving	3.4	4.9	4.6
	5.7%	Improving	6.8%	7.2%	7.3%
	26.4	Deteriorating	37.4	43.5	38.1
	22.8%	Deteriorating	20.6%	22.5%	20.5%
	48%	Deteriorating	49.3%	44%	49.2%
	2.2%	Similar to	2.6%	2.9%	2.8%

	Per pop	Actual
	100	5,304
	277	14,742
	98	5,200
	32	1,549
	15	739
	34	1,635
	17	170

KEY	
	= Worse than
	= Similar to
	= Better than

*Note: The colours denote Eden's comparative performance against Cumbria, the North West Region and England.

Eden sits in the East of the county. The administrative centre of the district is the market town of Penrith. Eden contains a number of other historic market towns including Kirkby Stephen, Appleby-in-Westmorland and Britain's highest market town Alston which can be reached by the scenic Hartside pass. Eden has a rich and varied natural landscape, which includes sections of the Lake District National Park including Ullswater, the countryside of the Eden Valley and the moorlands that make up the North Pennines, an Area of Outstanding Natural Beauty.

Eden is the least populated district in Cumbria with a current population 51,800 people. Eden has a geographical area of 2,142 km^2 and by far the lowest population density of all the districts in Cumbria with only 24 people per km^2. Eden is also the most rural district in the county with 71.3% of the population living in rural areas. The district's rural nature has a significant impact on some residents' ability to access essential services including schools, post offices, and GPs. Eden is the most deprived district in England in terms of geographical barriers to services.

The story of health and wellbeing in Eden is a positive one.

Levels of social and place wellbeing are high. The district has high levels of educational attainment, low levels of unemployment and a strong sense of satisfaction among residents.

Yet the district has significant issues around fuel poverty. The proportion of households that are fuel poor is the highest in Cumbria and over double the national average.

People living in Eden tend to make positive lifestyle choices. Levels of smoking, alcohol related harm and drug misuse are low, while the numbers who eat healthily and participate in sport are high. Despite this there is an issue around the level of childhood obesity which is the second highest in Cumbria.

The impact of major diseases on the residents of Eden is low. The district has the lowest premature mortality rates from cancer and circulatory diseases in Cumbria.
In terms of infant health the district's performance is positive and improving. Eden has the lowest rate of infant mortality and the lowest percentage of babies born with a low birth weight in Cumbria.

Eden Homeshare

Homeshare is a new and innovative scheme for Eden district. A Homeshare is simple: it's all about two people sharing a home. The first is the householder – usually they are an older person who could use some help and support around their home. The benefits for the householder are things like company, security, peace of mind and help around the home with tasks they may find difficult. The second person is the Homesharer, usually a younger person who needs somewhere to live and is willing to give some help and friendship in exchange.

A Homeshare is very much a two-way relationship; both people gain equally from the arrangement. The homeowner is given the help, support and security they need; the homesharer finds a place to call home, usually at reduced or no rent.

The process for interested parties is carefully managed by a Homeshare Coordinator who introduces compatible homesharers and householders to one another. Successful matches are based upon mutual interests and common values.

The project is hosted by Carlisle and Eden Age UK and a Homeshare Coordinator was appointed in September 2010. An advisory group, including representation from Public Health Cumbria, has been established and the first year of the project has concentrated on promoting the scheme and finding suitable matches. Recently a decision was taken to extend the scheme into Carlisle and at the time of writing several matches have now been established in both Eden and Carlisle.

Cumbrians get advice on how to 'Choose Well'

As the colder weather started to arrive, people across Cumbria were reminded of the importance of using the right NHS service for their needs during winter.

'Choose Well' is a national NHS campaign to help educate people of the importance of choosing the right NHS service for their needs as NHS services face added pressure over the winter months due to increased infections. The campaign also aims to remind people that A&E is for accident and emergencies only.

Flyers explaining the importance of 'Choose Well' landed on doormats across parts of Cumbria as a handy guide of health services that are available across the county.

As part of a winter health campaign, NHS Cumbria also sent letters, leaflets and room thermometers to the homes of people with the lung conditions collectively known as COPD (chronic obstructive pulmonary disease) to help them stay healthy this winter, did an extensive flu campaign to remind at-risk groups that they should have the seasonal flu vaccine to protect themselves from the complications which flu can cause, and launched 'Think Pharmacy' – a campaign to remind people across Cumbria of the free and confidential health services available at local pharmacies.

Furness_

Domain	Measure
Social and Place Wellbeing	1. % working age adults with level 4 or greater education
	2. Fuel poverty
	3. Excess winter deaths
	4. All benefit claimants
	5. % children living in poverty
	6. % who feel that they belong to their immediate neighbourhood
	7. % people who agree they can influence decisions in their area
Lifestyles and Health Improvements	8. Estimated smoking prevalence
	9. % of mothers smoking during pregnancy
	10. Hospital admissions due to alcohol (per 100,000)
	11. % reporting drunk and rowdy behaviour as a problem
	12. Estimated prevalence of drug misuse (crack and opiates) per 1000
	13. % of physically active adults (30 minutes, 5 times a week)
	14. % children participating in PE (3 hours of PE a week)
	15. % Healthy eating among adults (5 portions of fruit and veg a day)
	16. % of year six children obese
Health and Wellbeing Status	17. Mortality from all cancers <75 (per 100,000)
	18. Mortality from all circulatory disease <75 (per 100,000)
	19. Hospital admissions for neuroses (per 100,000)
	20. Admissions for deliberate self-harm (per 100,000)
	21. Mortality from suicide and injuries undetermined (per 100,000)
	22. Infant mortality per 1000 births
	23. % born with low birth weight (<2.5kg)
	24. Teenage pregnancy rate (aged 15-17) per 1000
	25. % working age population with a disability
	26. % working age adults with disabilities in employment
	27. % of 0-15 entitled to disability living allowance
Service Utilisation	Hospital emergency admissions per 1000 of the publication
	Calls to CHOC (Cumbria Health on Call) per 1000 of the population
	Calls to ambulance service per 1000 of the population
	Adult Social Care Service users per 1000 pop aged 18+
	Adults predicted to have Dementia per 1000 of the pop aged 18+
	Number of cared for known to ASC per 1000 of the pop aged 18+
	Children's Social Care Service users per 1000 pop aged 0-17

_Statistical Summary of **Furness**

		Trend	Comparisons		
	Furness	Compared to previous data	Cumbria	North West	England
	32.8%	Improving	30.9%	28.7%	31.3%
	28.5%	Deteriorating	28.1%	22.1%	18.4%
	6.8%	Improving	17	17.6	18.1
	19.8%	Similar to	13.8	18	14.4
	21.8%	Similar to	15.4%	23.1%	21.3%
	67%	Similar to	70%	no data	59%
	39%	Improving	39.7%	no data	29%
	28.9%	no data	21.5	23.4	21.2
	23.2%	no data	15.3	no data	no data
	2,528	Deteriorating	1896	2295	1743
	25%	Improving	20%	no data	no data
	12.4	Deteriorating	7.5	11.5	9.4
	15%	Improving	14.7%	11.2%	11.7%
	71%	no data	59.8%	57.9%	55.1%
	23.8%	Deteriorating	28.5%	26.2%	28.7%
	20.3%	Similar to	20.8%	19.7%	19%
	117	Improving	111	123	110
	86	Similar to	72	86	70
	29.6	Deteriorating	19	30.1	16.4
	330.6	no data	234.5	263.2	198.3
	5.8	Improving	9.1	9	7.9
	3.4	Similar to	3.4	4.9	4.6
	6.4%	Improving	6.8%	7.2%	7.3%
	38.6	Improving	37.4	43.5	38.1
	25%	Deteriorating	20.6%	22.5%	20.5%
	38.2%	Deteriorating	49.3%	44%	49.2%
	3.6%	Deteriorating	2.6%	2.9%	2.8%

	Per pop	Actual
	139	10,047
	192	13,870
	120	8,700
	39	2,832
	13	923
	44	3,211
	33	492

KEY	
	= Worse than
	= Similar to
	= Better than

* Note: The colours denote Barrow-in-Furness district's comparative performance against Cumbria, the North West Region and England.

Barrow-in-Furness district is in the South West corner of the county. The district is dominated by the town of Barrow the second largest settlement in Cumbria. Geographically isolated, with relatively poor transport links, the district is a historic centre of the ship building industry. Barrow-in-Furness also includes the small market town of Dalton in Furness.

At 78 km^2 Barrow-in-Furness has by far the smallest geographical area of any district in Cumbria. It is also the most densely populated district in the county with a current population of 70,700. The district is predominantly urban with only 18.2% of the population living in rural areas, compared to 51.2% of Cumbria's population as a whole.

Levels of health and wellbeing in Barrow-in-Furness district are low.

Barrow-in-Furness is the third most deprived district in England in terms of health.

The district has comparatively low levels of social and place wellbeing with the lowest proportion of people who report being satisfied with their local area in Cumbria. Levels of educational attainment in the district are comparatively low, while the rate of unemployment is the highest in the county.

The level of health inequalities in Barrow-in-Furness district is heightened by individuals' lifestyle choices and behaviours. The district has some of the highest rates of alcohol related harm in England. Barrow-in-Furness district also has the highest levels of serious drug misuse and proportion of smokers in the county.

Health inequalities are illustrated by the impact of major diseases on the residents of the district. Barrow-in-Furness has the highest premature mortality rate for circulatory disease in the county. While the premature mortality rate from cancer has improved it remains above the county and national averages.

The mortality rate from suicide and injuries undetermined in Barrow-in-Furness is the lowest in Cumbria, yet the district also has the highest rates of hospital admissions for deliberate self harm and neuroses in Cumbria. This suggests ongoing and significant issues around mental health in the district.

On a more positive note Barrow-in-Furness district had the lowest rate of excess winter deaths in Cumbria and the highest proportion of young people participating in P.E.

While Barrow-in-Furness performs poorly across a range of health and wellbeing indicators there are also significant health inequalities within the district with a 12.7 year gap between the wards with the highest and lowest healthy life expectancies.

Marsh Street Arches and Garden Community Growing Scheme

Located in the heart of Barrow's Central ward, this project will see an area of waste land developed into a large community garden which will be used by a range of local organisations and community groups including MIND, the Croftlands Trust, Barrow Dads Group and Age UK. With support and a small financial contribution from Public Health Cumbria, the project will encourage increased physical activity, promote the consumption of fruit and vegetables and help to reduce social isolation for participants.

You, Me and Afternoon Tea

A health and wellbeing flavour was added to *You, Me and Afternoon Tea,* a series of events organised for the whole community by a group of local churches. Topics covered at the popular sessions included keeping safe and warm in winter, falls prevention and carer issues; the event also provided an opportunity for older people to socialise in a safe and friendly environment. Participants were able to chat informally to Barrow Neighbourhood Wardens, Cumbria Fire and Rescue Service, the Parish Nurse Team and Barrow Community Safety Team during tea. Supported by Public Health Cumbria, Barrow Borough Council and Furness Carers, it is hoped that these events can be rolled out to other areas of the town during 2012.

Three thousand more Cumbrians feel the benefits of being smokefree

For the second year in a row, over three thousand smokers across Cumbria managed to kick the habit with help from free NHS services.

From April 2010 - March 2011 3,289 people managed to quit smoking with support from NHS services across Cumbria. This includes; community pharmacies, the Cumbria Stop Smoking Service and GP surgeries.

It's estimated that one in four people in Cumbria smoke and about 40 per cent of smokers will die from a smoking-related condition such as lung cancer, heart disease, stroke and other cancers.

The NHS offers totally free and confidential services to help people to stop smoking. Support includes one-to-one meetings or group sessions in a range of locations, advice over the phone or support from participating pharmacies.

For free help and advice to quit smoking contact the Cumbria Stop Smoking Service on 01900 324222 or by text 'QUIT' to 82540 to arrange an appointment or phone consultation. Alternatively stop smoking advice can be sought from participating community pharmacies and GP surgeries across Cumbria.

Live Your Life, Love Your Life

Public Health Cumbria is supporting Barrow Borough Council and the North West Evening Mail with the 2012 Live Your Life, Love Your Life campaign which launched in February with a public event. People in Furness were encouraged to pledge to make small lifestyle changes that will lead to improvements to their health and wellbeing; one of the aims is for the community as a whole to lose 500 metric tons of weight during 2012.

South Lakeland_

Domain	Measure
Social and Place Wellbeing	1. % working age adults with level 4 or greater education
	2. Fuel poverty
	3. Excess winter deaths
	4. All benefit claimants
	5. % children living in poverty
	6. % who feel that they belong to their immediate neighbourhood
	7. % people who agree they can influence decisions in their area
Lifestyles and Health Improvements	8. Estimated smoking prevalence
	9. % of mothers smoking during pregnancy
	10. Hospital admissions due to alcohol (per 100,000)
	11. % reporting drunk and rowdy behaviour as a problem
	12. Estimated prevalence of drug misuse (crack and opiates) per 1000
	13. % of physically active adults (30 minutes, 5 times a week)
	14. % children participating in PE (3 hours of PE a week)
	15. % Healthy eating among adults (5 portions of fruit and veg a day)
	16. % of year six children obese
Health and Wellbeing Status	17. Mortality from all cancers <75 (per 100,000)
	18. Mortality from all circulatory disease <75 (per 100,000)
	19. Hospital admissions for neuroses (per 100,000)
	20. Admissions for deliberate self-harm (per 100,000)
	21. Mortality from suicide and injuries undetermined (per 100,000)
	22. Infant mortality per 1000 births
	23. % born with low birth weight (<2.5kg)
	24. Teenage pregnancy rate (aged 15-17) per 1000
	25. % working age population with a disability
	26. % working age adults with disabilities in employment
	27. % of 0-15 entitled to disability living allowance
Service Utilisation	Hospital emergency admissions per 1000 of the publication
	Calls to CHOC (Cumbria Health on Call) per 1000 of the population
	Calls to ambulance service per 1000 of the population
	Adult Social Care Service users per 1000 pop aged 18+
	Adults predicted to have Dementia per 1000 of the pop aged 18+
	Number of cared for known to ASC per 1000 of the pop aged 18+
	Children's Social Care Service users per 1000 pop aged 0-17

_Statistical Summary of **South Lakeland**

		Trend	Comparisons		
	South Lakes	Compared to previous data	Cumbria	North West	England
	41.1%	Improving	30.9%	28.7%	31.3%
	28.3%	Deteriorating	28.1%	22.1%	18.4%
	20.1%	Deteriorating	17	17.6	18.1
	8.4%	Similar to	13.8	18	14.4
	8.9%	Similar to	15.4%	23.1%	21.3%
	73%	Similar to	70%	no data	59%
	44%	Improving	39.7%	no data	29%
	13.5%	no data	21.5	23.4	21.2
	10.9%	no data	15.3	no data	no data
	1,433	Deteriorating	1896	2295	1743
	14%	Improving	20%	no data	no data
	4.4	Improving	7.5	11.5	9.4
	14.3%	Improving	14.7%	11.2%	11.7%
	58%	no data	59.8%	57.9%	55.1%
	32.7%	Similar to	28.5%	26.2%	28.7%
	17.3%	Similar to	20.8%	19.7%	19%
	96	Similar to	111	123	110
	59	Similar to	72	86	70
	15.4	Deteriorating	19	30.1	16.4
	176	no data	234.5	263.2	198.3
	7.4	Improving	9.1	9	7.9
	4.6	Improving	3.4	4.9	4.6
	7%	Similar to	6.8%	7.2%	7.3%
	21.9	Improving	37.4	43.5	38.1
	23.1%	Deteriorating	20.6%	22.5%	20.5%
	63.4%	Deteriorating	49.3%	44%	49.2%
	2.2%	Similar to	2.6%	2.9%	2.8%

	Per pop	Actual
	102	11,007
	141	15,141
	115	12,298
	57.42	3,848
	27.2	1,823
	38	2,544
	14.3	278

KEY	
	= Worse than
	= Similar to
	= Better than

*Note: The colours denote South Lakeland's comparative performance against Cumbria, the North West Region and England.

Kendal is the largest town and administrative centre of South Lakeland. The district contains popular areas of the Lake District National Park including Lake Windermere, the Langdale Valley and the tourist towns of Bowness, Ambleside and Grasmere. The Lake District Peninsular's in the south of the district include the market town and industrial centre of Ulverston, the Edwardian resort of Grange-over-Sands and the Arnside and Silverdale Area of Outstanding Natural Beauty. In the east of the district sits the book town of Sedbergh which is part of the Yorkshire Dales National Park.

South Lakeland is the second largest district in Cumbria, after Eden, with a geographical area of 1534 km^2. It is also the second most populated district, after Carlisle, with a current population of 103,700 people. The district is predominantly rural in nature with 62.1% of the population living in rural areas. This rurality has a significant impact on some residents' ability to access essential services including schools, post offices, and GPs. A Lower Super Output Area in Whinfell ward is the 108th (out of 32,482) most deprived in England in terms of geographical barriers to services.

The story of health and wellbeing in South Lakeland is a positive one.

Levels of social and place wellbeing are high. The district has highest levels of educational attainment in Cumbria and low levels of unemployment. South Lakeland also has the highest proportion of residents reporting satisfaction with, and involvement in, their local area.

Residents of South Lakeland tend to make positive lifestyle choices. Levels of smoking and substance misuse are the lowest in Cumbria, while levels of healthy eating are the highest. In contrast levels of physical activity are below the county average.

The impact of major diseases on the residents of South Lakeland is comparatively low. The district has the second lowest premature mortality rate from cancer and the lowest premature mortality rate from circulatory diseases in the county. South Lakeland also has the lowest rate of teenage pregnancy in Cumbria, reflecting the overall low levels of risk taking behaviour in the district.

There is a significant issue regarding the rate of infant mortality in South Lakeland which while falling remains the highest in Cumbria. The district also has the second highest percentage of babies born with a low birth weight in Cumbria.

Healthy Homes Action Group

The Healthy Homes Action Group has continued to focus on providing Winter Warmth and Energy Efficiency information and support to people in South Lakeland, particularly focusing on older adults. The main event for this last year was an Energy Efficiency Tea Dance, which was held in November 2011 at the Coronation Hall in Ulverston which was attended by over 100 people. Those attending received a free 'goody bag' containing lots of information on keeping warm and well in winter and what support services are available locally. They also received some energy saving products for the home as well as entry to a free prize draw, with prizes themed around keeping warm such as thermal gloves, cuppa soups, thermal socks and hot water bottles. As well as being an opportunity to keep warm and become active, a number of agencies and organisations including the Police, Fire Service, Trading Standards, Age UK and Citizens Advice Bureau were available to talk to people about any issues or concerns or requests for help and assistance.

Alcohol Brief Intervention

South Lakeland Locality identified alcohol related harms as an area of concern and wished to reduce the harmful use of alcohol by patients. To address this they included the delivery of alcohol brief interventions within a Locally Enhanced Service (LES), entitled Referral Support 2011/12. The LES rewards practices for delivering alcohol brief interventions to any patient aged 16 years and over, so building on alcohol screening delivered under the Designated Enhanced Service (DES), which applies only to new patients.

The aim of the LES is to provide improved capacity and awareness of alcohol brief interventions among primary care clinicians. This will be achieved by providing brief intervention training to ensure a standardised high quality intervention with patients whose use of alcohol could result in harm. Public Health Cumbria was engaged to develop and deliver this training. The training consisted of an overview of the LES, the theory underpinning brief intervention approaches, the gold standard screening tool AUDIT C and the provision of resources available to support clinicians in this work.

Monitoring of the LES is currently underway to establish what effect it has had since its introduction and the LES has been extended into this year 2012/13. Consideration is being given to further training designed to support extended interventions for those patients that are identified as drinkers at increased risk of harm.

Alcohol and Young People

The South Cumbria Alcohol Strategy Steering Group formed a task group to look at Proxy sales and 'pre-loading', which is where youngsters drink strong spirits or 'shots' in order to quickly raise their blood alcohol levels and quickly become intoxicated. During Alcohol Awareness week in November some young people visited Trading Standards and South Lakeland District Council Licensing department in Kendal, to gain an understanding of the effects alcohol has on the work of the organisations. Students at Kendal College received a presentation about 'pre-loading' and the problems it brings and students designed materials for the Christmas poster and beer mat campaign.

Section 2_

Childhood Epilepsy

This section focuses on childhood epilepsy. I have chosen this topic because epilepsy is an example of a long-term condition which can seriously compromise the sufferer's quality of life, yet in recent years it does not seem to have been very high on the public health agenda. Epilepsy is the most common serious disorder of the brain, affecting an estimated 460 children and young people in Cumbria. In addition, epilepsy still wrongly attracts stigma, despite improved understanding of how the brain works and the development of effective treatments. I outline the scale of the problem posed by epilepsy, and best practice in managing epilepsy. I conclude with a case study, which gives an insight into the experience of living with this condition in Cumbria and then give my recommendations for epilepsy development in Cumbria.

What is epilepsy?

The term 'epilepsy' refers to conditions in which changes in the electrical activity of the brain result in seizures.

The cells in the brain, known as neurons, communicate with each other with electrical impulses. During a seizure, the electrical impulses are disrupted, which can cause the brain and body to behave strangely.

The severity of the seizures can differ from person to person. Some people simply experience a 'trance-like' state for a few seconds or minutes, while others lose consciousness and have convulsions (uncontrollable shaking of the body). Seizures usually last only a few seconds or minutes and then the brain activity returns to normal.

Seizures fall into two main categories: generalised seizures, which affect the whole brain and during which people become unconscious of their surroundings, and focal (or partial) seizures, which affect only one part of the brain.

Depending on which part of the brain is affected, people's experiences during a seizure can take many forms. This can include changes in body movements or behaviour, to changes in the way you feel or your emotions, and the way that sensations are experienced.

Epilepsy affects around 456,000 people in the UK. This means that about 1 in 130 people have epilepsy. Epilepsy usually begins during childhood, although it can start at any age.

In common with other serious long-term health conditions, epilepsy can impact on the psychological, educational and social wellbeing of children and young people affected, as well as their siblings and families.

Types of epilepsy

Epilepsy has been known for at least 3,000 years. In times past, some believed it was a supernatural, demonic or spiritual disorder. However, Hippocrates (c. 400 BC) and his followers regarded epilepsy as a physical disorder due to natural causes. Even today, epilepsy can still wrongly attract stigma. There are three main types of epilepsy:

- Symptomatic epilepsy - the symptoms of epilepsy are due to damage or disruption to the brain.
- Cryptogenic epilepsy - while no evidence of damage to the brain can be found, other symptoms, such as learning difficulties, suggest that damage to the brain has occurred.
- Idiopathic epilepsy - no obvious cause for epilepsy can be found.

The different types of epilepsy have different causes. Some cases of epilepsy are due to inherited or genetic disorders. Others can arise from problems during birth (e.g. lack of oxygen), infection of the brain or head injuries. The cause of epilepsy is unknown in many children and young people.

At the moment, there is no cure for epilepsy. Anti-epileptic drugs are usually the first choice of treatment and about 70% of people with epilepsy have their seizures controlled with them.

People with epilepsy have a mortality rate significantly higher than that of the general population. It is estimated that over half (59%) of the deaths of children and young people with epilepsy are probably or potentially avoidable.

When somebody with epilepsy dies and no apparent cause can be found, it is known as sudden unexpected death in epilepsy (SUDEP). SUDEPs are rare, affecting only 0.5% of people with severe epilepsy. The causes of SUDEPs are unknown, but one theory is that seizures could affect the person's breathing and heartbeat. The risk of SUDEP is increased in young adults living alone and people with poorly controlled epilepsy and seizures that occur during sleep.

How common is epilepsy in children and young people?

Epilepsy affects around 60,000 children in the UK. About 460 of the 110,000 Cumbrians aged 19 years and under are estimated to have epilepsy. On average there is one child with epilepsy in every primary school, and five in every secondary school.

Epilepsy can affect learning, memory and behaviour. Up to half of children with epilepsy may be underachieving at school and an estimated 16% of children with epilepsy have an emotional disorder, compared to 4% of their peers.

Schools and communities, as well as health services, play important roles in enabling children and young people affected to live their daily lives to the full.

Developing epilepsy care

Reducing unplanned hospitalisation for asthma, diabetes and epilepsy in people under the age of 19 is a priority for the NHS. In Cumbria, work is underway to reduce emergency admissions by improving care pathways for children and young people – with a focus on promoting a greater range and use of community based and self managed care – and delivering a more integrated response to care needs in hospital accident and emergency departments.

Experience from other parts of the country is being used to support the development of the service model for epilepsy care in Cumbria. For example, the introduction of a specialist epilepsy nurse into a multi disciplinary care team in the Midlands was accompanied by a halving of admissions. Young Epilepsy, a voluntary organisation committed to improving the lives of young people with epilepsy (see www.youngepilepsy.org.uk) is sharing its national experience and expertise with health commissioners in Cumbria.

How is epilepsy diagnosed?

Diagnosing epilepsy can be a complex and lengthy process.

A person in whom a seizure is suspected should be assessed by a healthcare professional. This is likely to be a GP or doctor at the hospital emergency department in the first instance. If they think that an epileptic seizure may have taken place, the person should be referred within two weeks to a specialist. For a child or young person, the specialist should be a paediatrician with special training in diagnosing and treating epilepsy.

Using information about what happened during the seizure and any other symptoms, the specialist may be able to establish whether the person has epilepsy and if so, the type of epilepsy and the treatment that is likely to work best. The specialist may order tests such as an 'electroencephalogram', (EEG), which records the brain's electrical activity, and 'magnetic resonance imaging', (MRI), which uses magnetic fields to produce a picture of the brain.

Treatment for epilepsy

There are effective treatments that can prevent seizures happening. The goal of epilepsy treatment is seizure freedom without intolerable side effects. Epilepsy can be controlled in two thirds of people with modern anti-epileptic drugs (AEDs).

Children with epilepsy that is hard to treat or complicated for other reasons should be referred to a team of healthcare professionals in a specialist centre. In more serious cases, surgery, ketogenic dietary treatments or vagus nerve stimulation may be recommended.

Treatment and care should take into account people's needs and preferences. People with epilepsy should have the opportunity to make informed decisions and agree a care plan, in partnership with their healthcare professionals. If the person is under 16, healthcare professionals should follow the guidelines in 'Seeking consent: working with children'. This Department of Health booklet provides guidance to healthcare practitioners on how to seek consent from children in their care. All children and young people with epilepsy should have a structured review at least every year by a specialist.

Our experience in Cumbria with the approach to Type 2 diabetes, which seeks to support patients with the condition to be their own health expert, gives an indication of how we should be developing services for epilepsy.

People with epilepsy live with the condition for 24 hours a day, 7 days a week, 365 days of the year, and their contact with a health professional is at most likely to amount to a few hours annually. To ensure optimal control, quality of life and wellbeing, sufferers need to be fully conversed with their condition and how best to manage it, with intermittent professional support.

NICE Guidance

The National Institute for Health and Clinical Excellence (NICE) first produced guidance on the management of epilepsy in adults and children in 2004. This was updated in January 2012. This NICE Clinical Guideline (CG 137) offers evidence-based advice to help healthcare professionals, patients and their carers to make decisions about treatment and healthcare. In addition, NICE has developed an epilepsy pathway covering diagnosis, information, investigations and treatment and management of the condition. The main recommendations of NICE CG 137 are outlined below. Information for the public about the Guideline is available at **www.nice.org.uk**.

People with epilepsy are likely to receive treatment and care from more than one healthcare professional. A named clinician should be responsible for the ongoing management of children and young people with epilepsy. They should have easy access to multi-disciplinary services such as speech and language therapy, learning disability and psychology. Whenever possible, an epilepsy specialist nurse should be involved in the care of children and young people with epilepsy.

Arrangements should be made to ensure a smooth transition to adult services. Before a young person moves to the adult service, their diagnosis and treatment should be reviewed. They should also be given up-to-date information on support groups and charities and help to contact them.

Getting the right support

People with epilepsy (and their family and carers) should receive information on their condition that is tailored to their needs. Information should be available to people with epilepsy about:

- diagnosis and treatment options, including any possible side effects of medications
- what can trigger seizures and how to control or avoid them
- what's likely to happen in the future
- how to manage living safely with epilepsy, including advice about first aid
- psychological issues, such as depression and anxiety
- practical issues such as social security benefits, insurance issues, driving and road safety
- education and healthcare at school
- employment and independent living for adults
- reducing the risk of sudden death caused by epilepsy
- status epilepticus
- how epilepsy can be affected by, and can affect, lifestyle (for example, the use of illegal drugs, alcohol, sexual activity and the effects of not getting enough sleep)
- family planning and pregnancy
- local and national support groups and charities

What additional care and support should children and young people with epilepsy receive?

When providing care and treatment for any condition experienced in childhood, the young person's physical, psychological, educational and social needs should be addressed holistically. Special attention needs to be paid to their relationships with family and friends and at school.

Schools have an important role to play. Organisations such as 'Young Epilepsy' offer practical assistance to schools and can run activities to help students and staff gain a better understanding of epilepsy. Good communication between school staff and children and young people with epilepsy, their parents and health professionals is essential.

Schools should ensure that staff are trained to deal with seizures; that children and young people with epilepsy are included in activities, and do not experience isolation and stigma; and that achievement and behaviour are monitored.

An assessment of educational needs should be undertaken to identify any extra support required. The school's Special Educational Needs Coordinator (SENCO) or School Nurse may be able to provide additional support.

Epilepsy – a parent's experience

Jill Jones is the mother of Steve, who was diagnosed with epilepsy when he was seven. He is now 15. They live in Millom. This is her experience of having a child with epilepsy.

Steve was seven when he had his first seizure - about ten years ago now. Looking back, there may have been some symptoms earlier; he was slow learning to talk, and still struggles with his handwriting and spelling.

After the first seizure we were referred to the local consultant paediatrician, who told us that Steve had a benign form of epilepsy and that he would probably grow out of it. Having discussed treatment options, we chose not to start medication immediately. Although the paediatrician was very helpful, we weren't given much other information about epilepsy at that point.

Over the following couple of years, Steve continued to have seizures every six months or so, always in his sleep, and especially when we were away from home or when he was really tired. These were at times quite scary for my partner and I, and although Steve wasn't aware of most of his seizures, he woke once and described being really frightened and feeling 'locked in', with nothing he could do about it.

We went back to our doctor, and this time we were referred to a paediatric neurologist who was great. We decided to start medication; the turning point was hearing about the increased risk of death in people who experience seizures at night.

From the start we have tried to put Steve in charge of his treatment. For Steve, we found a suitable medication quickly and after two years without seizures we were advised that he could discontinue medication, but as he had some school trips and summer holidays coming up he decided he didn't want to come off his medication at that point. So we waited until he was ready, then with advice we slowly reduced the dose.

Fortunately Steve's school has been very supportive. Their involvement has been really important both from an educational as well as a social perspective. His teachers have done everything possible so he can take part in school trips and school activities, including learning what to do in an emergency.

With hindsight, it would have been good to had more information on the condition from the start, and to see a specialist earlier. But we have been lucky in many ways: Steve no longer has seizures and when he had them, they always happened at night. If they had been in the day, I can imagine how anxious we would have been about letting him do some of the things he really enjoys, like cycling, or sailing, and it could have been more difficult for his siblings and friends to deal with.

Epilepsy can be a difficult condition to live with, but with the right support, guidance and treatment it can be managed very well at home.

Optimising the care of children and young people with epilepsy

The annual cost of epilepsy to the NHS and society as a whole is estimated to be about £2 billion. In a health economy where resources are finite, it is important to ensure that we maximise value by achieving the best possible outcomes for people with epilepsy in the most cost effective way.

It is estimated that if everyone affected received optimal treatment, the proportion of people with epilepsy who are free from seizures could increase significantly – for adults this proportion could increase from about 52% to 70%.

Similarly, reducing the number of people incorrectly diagnosed with epilepsy, currently estimated at about 20% - 30%, would have clear economic as well as health benefits.

The introduction of newer anti-epileptic drugs also needs to be carefully managed as pressures on NHS budgets increase.

National research shows that too few of the estimated 400 children with epilepsy in the UK who could benefit from surgery are currently offered it.

Another way of improving the care of children and young people with epilepsy, and at the same time achieving savings to the NHS, is by reducing unnecessary hospital admissions. Cumbria has a relatively high rate of emergency hospital admissions for children with epilepsy at 100 per 100,000 (NHS Atlas of variation 2011). This is higher than the national average. People with epilepsy should be supported so that they can manage their condition without having to be admitted to hospital, if possible. It is estimated that savings of over £40,000 could be achieved by reducing these emergency admissions to a rate equivalent to the average of the best 25% of primary care trusts.

What to do if someone has a seizure

It may be scary to see someone having a seizure, but don't panic. If you see someone having a seizure, whether it is caused by epilepsy or not, there are some simple things you can do to help:

- move them away from anything that could cause injury, such as a busy road or hot cooker;
- cushion their head if they're on the ground;
- loosen any tight clothing around their neck, such as a collar or tie, to aid breathing;
- when their convulsions stop, turn them so that they're lying on their side;
- stay with them and talk to them calmly until they have recovered;
- note the time the seizure starts and finishes.

Don't put anything in the person's mouth, including your fingers. They may bite their tongue, but this will heal. Putting an object in their mouth could cause more damage.
As the person is coming round, they may be confused, so try to comfort and reassure them.

Should I call an ambulance?

You don't necessarily have to call an ambulance because people with epilepsy don't need to go to hospital every time they have a seizure. Some people with epilepsy wear an identification bracelet or carry a card to let medical professionals and anyone witnessing a seizure know that they have epilepsy.

However, **dial 999** if:

- it's the first time someone has had a seizure;
- the seizure lasts for more than five minutes, or;
- the person doesn't regain full consciousness, or has a series of seizures without regaining consciousness.

Make a note of what happens during the seizure as this may be useful for the person or their doctor.

Support for parents and carers

Caring for a child or young person with epilepsy can be challenging and evoke feelings ranging from shock, worry and sadness to anger and helplessness. Talking to other people with experience of epilepsy can help.

Many individuals and voluntary organisations offer peer support, signposting and information for parents and families. These include:

Young Epilepsy which offers information, education and training about epilepsy for young people, their families and the professionals working with them, and help for schools.
www.youngepilepsy.org.uk
Tel **01342 831342**

Contact a Family which puts families in touch with other families and local parent support groups.
www.cafamily.org.uk
Tel **0808 808 3555**

Face2Face which offers a one-to-one befriending service for parents of disabled children. **www.face2facenetwork.org.uk**
Tel **0844 800 9189**

Other sources of information and advice include:
NHS Choices www.nhs.uk

Epilepsy Action
Tel **0808 800 5050 www.epilepsy.org.uk**

Epilepsy Society
www.epilepsysociety.org.uk Tel **01494 601400**

Matthew's Friends - Dietary Treatments for Epilepsy
www.matthewsfriends.org
Tel **01342 836571** or **07884 054811**

Joint Epilepsy Council
www.jointepilepsycouncil.org.uk

Epilepsy Bereaved
Tel **01235 772852**

Recommendations:

People with epilepsy should be supported so that they can manage their condition without having to be admitted to hospital if possible. A high number of people admitted to hospital as emergencies because of their epilepsy may indicate that they're not being adequately supported to manage their condition or are not being diagnosed. However, not all admissions to hospital are avoidable, and the rate of emergency admissions will be affected by a range of factors.

To improve epilepsy care in Cumbria, I recommend:

- A review of current service provision and community assets should take place to inform the development of an integrated epilepsy care pathway.
- Development of nursing expertise in child epilepsy care, to ensure coordination of care pathways across primary and secondary care, family support, patient education and a link to school health services.
- The development of an epilepsy network to share best practice on epilepsy care to help improve seizure control and support clinical decision making about the need for admission.
- A review into the transition of children with epilepsy from paediatric to adult epilepsy services.

Section 3_

Working age adults and the recession

This section focuses on the effects of the recession on health and wellbeing.

The UK has been experiencing a turbulent economy for a number of years, and I have chosen this topic to focus on the potentially negative impacts that financial downturn can have on an individual's health and the health of the family unit. Problems can be numerous, from stress due to work load or financial pressures, depression caused by unemployment, or the strain of debt on a household, which can lead to fuel poverty, poor living conditions and can contribute to poor diet. I explore some of the effects of worklessness, some local initiatives to tackle workforce wellbeing and conclude with recommendations to support positive employment and healthy workplace initiatives in Cumbria.

Deprivation is not solely an issue of finance, but what Professor Richard Titmuss of the London School of Economics described as "control over resources through time", resources including education, supportive environment and social returns.

Economic performance and national prosperity are known key determinants of health and wellbeing. When society is experiencing a buoyant economy with high employment, the benefits associated – from increased disposable income, greater freedom to enjoy leisure time or the perception of more control over life – there are higher levels of reported wellbeing. When employment rates were at their highest in the early 2000s, there were high levels of satisfaction in the Cumbria tracker survey, the countywide public opinion survey. However, conversely when times are hard, particularly over a sustained period of time, rates of common mental health conditions - stress, depression and anxiety – increase and satisfaction levels slump.

As expected, those most at risk from the economic and social effects of a recession are those on low incomes and those already categorised as disadvantaged, which may be sub-divided into the elderly, the disabled and young families. Importantly, during a recession, many more people will fall into an "at risk" category because their circumstances change, often through no fault of their own, for example through redundancy.

Employment in Cumbria

Employment in Cumbria is mainly based in the manufacturing and tourism sectors; reflecting the nuclear and shipbuilding industries in Copeland and Barrow-in-Furness, and the economic role of the Lake District National Park and other tourist attractions. Levels of unemployment in Cumbria are below the national average; however there are sharp contrasts across the county with high unemployment levels in the urban areas of Barrow and Copeland.

Wages and salaries in Cumbria are relatively low with earnings in particular areas significantly lower than national and regional averages. The average median household income in Cumbria is £26,004, falling to £22,835 in Barrow-in-Furness. This compares to £28,989 for the rest of the UK.

As of February 2012 there were 5.7 job seekers to every unfilled job vacancy in Cumbria, again similar to national levels. However the claimant (job seeker) to vacancy ratio rises to 12.9 in Barrow-in-Furness reflecting the high levels of unemployment and lack of job opportunities in the district. In contrast there are less than two job seekers to every unfilled vacancy in South Lakeland.

1,123 more people in Cumbria are claiming Job Seekers Allowance (JSA) than a year ago, a rise of 12.9% over the year. The claimant count rose in Allerdale (35), Barrow (54), Carlisle (123) and South Lakeland (51) but fell in Copeland (-22) and Eden (-3). It is also higher nationally than a year ago but by a smaller margin of 9.6%.

The claimant rate in Cumbria is up by 0.4 compared to a year ago, reaching 3.2% the highest level since January 2000. The national rate is also up by 0.4 to 4.2%.

Nationally, we have not seen youth unemployment figures as high since the early 1980s when the distress of young people was accompanied by large increases of drug abuse. A third of all claimants, 3,345, were young people aged 16-24. Overall, 6.7% of all people in this age group are claiming JSA, just below the national average of 6.8% but more than double the rate for the population as a whole in Cumbria. JSA Claimant rates for young people in Allerdale (8.1%), Barrow (9.4%) and Copeland (8.9%) are higher than nationally.

Levels of educational attainment in Cumbria are similar to those at a national level, with 30.9% of adults having achieved a certificate of higher education (level 4 or above). At GCSE level 56.3% of 16 year olds achieved 5 A*-C grades including English and Maths just below the national average of 57.9%. There are wide variations in levels of educational attainment within Cumbria with 91.7% of pupils in Kendal Highgate ward gaining 5 A*-C grades including English and Maths compared to just 25.9% in Mirehouse ward in Whitehaven.

(Data from Cumbria Intelligence Observatory).

The effects of economic recession

Although rates of employment are the most readily available data sets to demonstrate the impact of a recession, it is important to recognise that other proxy indicators can provide a picture of the overall effects of recession on health and wellbeing.

Recession is not simply about direct jobs and personal earnings. It begins to have an effect on many aspects of community life and society such as viability of shops and businesses, modes of transport (in terms of individual affordability as well as a reduction in community services – for example cutbacks may lead to a reduction in regular public transport routes), rates of learning and availability of opportunity to go into further education, housing choices and affordable warmth.

Even a mild recession will put more pressure on families and increase the likelihood that more of them will break up, levels of debt increase, and crime, violence and levels of anti-social behaviour have also been shown to increase during a recession. The following indicators demonstrate some of the impacts of economic downturn:

Business failure rates

Measuring indicators such as local business failure rates can point to potential health issues in the future, especially if those businesses are providing vital services and supplies to a remote rural community. This will be in sharper focus during times of recession when that community may have far fewer choices or alternatives due to fuel costs and other factors.

The failure of a business due to the recession therefore does not only affect the business and those working in or with it, it can also have a serious effect on the community and the environment in which it operates.

Affordable Warmth

Energy prices are at an all time high and many households are falling into fuel poverty (where a household spends more than 10% of its income on fuel). Fuel poverty is associated with excess winter deaths. Levels of fuel poverty in Cumbria are estimated to be higher than England as a whole with particularly high levels in Barrow-in-Furness and rural areas of Eden. The level of fuel poverty almost doubled in Cumbria between 2005 and 2009 from 13% of households to 22% of households.

During times of economic pressure fuel poverty affects households in deprived areas even more as fuel subsidy is rare and usually restricted to a one off cold weather payment amongst the elderly. There is evidence that the poorest households are the most likely to be on pre payment or card meter schemes which are often the most expensive energy tariffs on offer and do not attract the discounts associated with direct debit schemes. This means that the poorest families are potentially paying higher prices in any case, but when household income is reduced it can mean that families are faced with no choice but to limit the amount of energy used. Over a long period this is likely to lead to health problems, poor housing conditions and a widening of the health inequality gap.

In Cumbria there has been a great deal of collaboration in the development of an 'Affordable Warmth Strategy' which seeks to work with a range of stakeholders in Cumbria including energy providers and home insulation companies to ensure that the most vulnerable can access affordable energy and maintain fuel efficient homes. This is closely linked to the Cumbria Housing Strategy in which the health economy also plays a strong part. It is vitally important that these partnerships are continued as it is only by working together that we can tackle the range of complex issues.

The cost of energy is a good illustration of the general fact that poor people pay more for most essential commodities, either because they do not have access through internet purchase, or that they are unable to take advantage of purchasing larger quantities at lower rates.

Mental Health and Wellbeing

The number of people suffering stress, anxiety and depression because of redundancies, job insecurity and pay cuts owing to the recession has increased since the economic downturn began. There is already evidence internationally of increases of suicide rates in some countries that parallels the economic crisis (The Lancet, Volume 379, Issue 9820, Pages 1001 - 1002, 17 March 2012).

Studies have found that worries about the effects of the downturn have produced a sharp rise in people experiencing symptoms of common mental health conditions, such as anxiety.

Nationally, cases of depression have increased by between four and five-fold as unemployment, cuts in hours and concern about security of tenure have become common.

Among people who lost their jobs in the in 2009/10, 71% have suffered symptoms of depression, 55% have experienced stress and 52% experienced symptoms of anxiety (ref Roehampton study).

Poorer health

As people are forced to economise and reduce their outgoings, many find they have little choice but to spend less on the fundamentals of food and heating.

The elderly and disabled in particular are more likely to suffer from poor diet and live in an inadequately heated home, with all the attendant health problems. They may go out less and become more isolated.

However, equally recession may also lead to some positive health benefits as less disposable income means people drink less, smokeless and may eat healthier food, cooking at home more and eschewing expensive fatty foods.

Debt management

The current downturn has led to a housing market crash, which for some has even led to the repossession of their homes. As the recession continues to bite, credit becomes much less readily and cheaply available. People will need to learn to live much more within their means – or risk further and unsustainable levels of personal debt. As household income becomes more squeezed there is an increased likelihood for some households to borrow at unaffordable rates and therefore go into debt.

Money worry and debt places strain on individuals and relationships, potentially leading to mental health and other health problems as well as relationship breakdown and the range of health and social problems which could result.

Avoiding debt

In Cumbria the DRAMA project (Debt Rescue and Money Advice) offers loans to its members. One of the major objectives of offering these loans is to remove the need to use doorstep lenders and loan sharks, as well as raising the level of financial literacy amongst the local community to empower them to make informed financial decisions. DRAMA, which is a Cumbrian partnership of major social housing providers, local authorities, credit unions and Citizens Advice Bureaux, has been delivering the scheme for nearly three years.

Public Health Cumbria has a nominated financial inclusion lead which acknowledges the important role that debt and income has on health and wellbeing.

Worklessness

Unemployment can have a dramatic effect on wellbeing which may widen health inequalities. Evidence shows that chronic illness is more common in disadvantaged groups making that group more susceptible to leave the labour market. Once unemployed, an individual and their family are at risk of falling into poverty and becoming socially excluded. Poverty and unemployment may cause a further deterioration in their health and consequently further worsen their employment prospects.

Nationally, the sheer scale of the numbers of people on incapacity benefits represents a historical failure of health care and employment support to address the needs of the working age population in Britain. The problem is not just with the existing caseload. Each year, 600,000 people move onto incapacity benefits. The system is failing those with common health conditions.

The national cost of benefits reduces the public funds available for other initiatives. It therefore follows that working with a range of partners to maximise employment prospects in Cumbria and reduce the number of people on benefits would not only result in health benefits, it would ultimately free up funds for investment in other areas.

Employment and health inequalities

In general terms, those in work enjoy better health, and unemployment is often more likely to lead to health problems, both physical and mental. Additionally, good work is even better for health. Securing and maintaining employment and improving the quality of jobs is therefore of vital importance in reducing health inequalities.

The working environment can have a high impact on the health of an employee, both in terms of the physical aspects (location, equipment, health and safety elements) and other factors such as workloads and levels of control. Jobs which have high demands, low levels of control and lower levels of remuneration are very often the jobs most available to the most disadvantaged groups. This exacerbates the issue of health inequalities and highlights that securing good quality work can be as important as securing work if we seek to tackle those inequalities in the longer term.

This is addressed in the Marmot Review's Policy Objective C: *Create fair employment and good work for all*. The review, undertaken by Professor Sir Michael Marmot looks at the most effective evidence-based strategies for reducing health inequalities in England from 2010. The review states that 'work is good – and unemployment bad – for physical and mental health, but the quality of work matters…jobs need to be sustainable and offer a minimum level of quality, to include not only a decent living wage, but also opportunities for in-work development, the flexibility to enable people to balance work and family life, and protection from adverse working conditions that can damage health'.

The Review proposes priority objectives to:

- Improve access to good jobs and reduce long-term unemployment across the social gradient.
- Make it easier for people who are disadvantaged in the labour market to obtain and keep work.
- Improve quality of jobs across the social gradient.

'Fair Society Healthy Lives' (The Marmot Review) The Marmot Review was published in February 2010. It concluded that reducing health inequalities would require action on six policy objectives:

1. **Give every child the best start in life**
2. **Enable all children, young people and adults to maximise their capabilities and have control over their lives**
3. **Create fair employment and good work for all**
4. **Ensure healthy standard of living for all**
5. **Create and develop healthy and sustainable places and communities**
6. **Strengthen the role and impact of ill-health prevention.**

Cost of work related illness

Work related illness costs are significant in the UK. The costs can be quantified in terms of welfare benefits for the unemployed, those with disabilities and those with health impairments. In addition, however, there is a large proportion of cost borne by employers in terms of lost productivity.

The total annual economic cost of ill health in terms of working days lost and worklessness is estimated at over £100 billion. This is equivalent to the annual running costs of the National Health Service. The Confederation of British Industry estimated that in 2007, 172 million working days were lost due to absence, costing employers £13 billion.

Improving health at work

There is a growing body of evidence indicating the action that is needed to improve health at work, support people when they become ill at work and to help those people who are out of work return to sustained employment. Far beyond the workplace we have to ensure that we work with as many partners as possible to avoid the wider health impacts of recession on our communities.

There is clearly a strong business case for investing in employee health and wellbeing. Organisations that prioritise staff health and wellbeing can reduce the level of staff turnover and sickness absence, and therefore reduce costs. However it is also the case that these organisations perform better, with improved customer satisfaction, stronger quality scores and better outcomes.

There is also a pressing need for practitioners within the health economy, in particular public health, to work further upstream with a broad range of stakeholders to prevent and avoid any illness which affects the ability to work but also to work even more broadly in areas that could lead to worklessness.

The Cumbria Mental Health and Wellbeing Strategic Framework recognises the role of work in mental wellbeing and makes important partnership links to initiatives such as The Employers Bridge which specifically focuses on mental health wellbeing and work.

The Employers Bridge

Many employers and businesses face particular challenges in the current financial climate, with the need to minimise costs and improve productivity. The ability to reduce sickness absence and employee turnover are therefore essential. Stress, stress related illness, depression and anxiety are the cause of more working days lost than any other work related illness. Sick pay reduces profits, and 'the bottom line' for a business can be the difference between success and failure in today's financial climate. Loss of valued and talented people also costs more than money.

The Employers Bridge has been created in Cumbria to give employers and employees access to a range of organisations and resources which can prevent mental ill health, absence from work and long-term sickness.

The Employers Bridge (Cumbria) project has been funded through the Individual Placement and Support Programme by The Strategic Health Authority and NHS Cumbria with contributions from other stakeholders so that employers can access the resources they need. The project provides a support and advice network to improve mental health and wellbeing at work.

Workplace Wellbeing

The Cumbria Workplace Wellbeing Charter and its associated toolkit enables employers to quantify the costs of sickness absence, turnover, worker ill-health and injury. Training is available free of charge for small to medium size enterprises, and the Health and Safety Executive provides a series of tools for employers to implement management standards to reduce workplace stress.

In unionised employment, the Trades Union Congress also has a structured approach to workplace wellbeing which forms a part of the Cumbria Charter scheme. This scheme means that employers have to take a strategic view of their workforce in terms of health needs and any gaps in standards which may be present in the workplace. A key part of the scheme is to encourage individual behaviour change but there is also evidence that workplace-based support for promoting healthier lifestyles is most effective if implemented alongside changes to the working environment.

With the publication of Dame Carol Black's review, *Working for a Healthier Tomorrow*, in March 2008, the issue of health, work and wellbeing and the links between them are now firmly on the Government's agenda. In response to this review, a range of initiatives have been introduced to improve the health and employment prospects of working age people. One of these initiatives saw the sickness certification system being replaced by a fit note pilot, helping GPs to switch the focus of advice to what people *can do* rather than what they *cannot*, the asset rather than the deficit approach.

Tackling barriers to employment

Given the diverse geography in Cumbria and the wide variations in employment patterns within the county it is perhaps unsurprising to find a wide range of local initiatives to tackle barriers to employment and to enable people to become work-ready, including:

The Condition Management Programme

The Condition Management Programme is the principal health service intervention focusing specifically on removing health barriers to employment. The programme aim is to tackle deep-seated barriers to work such as anxiety and lack of confidence. Widely varying models of delivery have been adopted throughout the country, but in Cumbria delivery is through a strong partnership between Jobcentre Plus and Cumbria Partnership NHS Foundation Trust. Early evaluations indicate effectiveness in improving people's capacity for work. There is scope to improve the uptake of this scheme through better integration into NHS care pathways for people with long-term conditions and mental health problems.

Routes 2 Work

Routes 2 Work works across West Cumbria, one of the most deprived communities in the UK. West Cumbria has been in economic decline for more than 30 years with many households experiencing second and third generation unemployment.

Derwent and Solway's Routes 2 Work initiative acts to tackle the unemployment problem within the local community. Its clients include people with mental health problems, homeless people, ex-offenders and people with drug and alcohol addictions.

Offering bespoke training packages to individuals as well as helping with the hidden costs of returning to work, amongst them travel costs, work clothes and toll that may be required. In recognition of Routes 2 Work's approach to tackling worklessness, Derwent and Solway have been awarded by the Housing Corporation a prestigious Gold Award for tackling worklessness. The award recognises Routes 2 Works commitment to breaking through the unemployment barriers in West Cumbria.

As well as individualised return to work support there is a need for continued job creation and investment programmes across Cumbria and a need for these programmes to be informed by a public health perspective through various partnership forums.

Working for a healthier tomorrow in Cumbria

To improve outcomes in Cumbria, we need to continue to strive to achieve the Marmot Review objectives of fair employment and good work for all in Cumbria during a period of high unemployment, but we will need to work ever closer with our partners to mitigate the wider effects of the recession on mental health, relationship breakdown, debt management and fuel poverty. Joint local action is the best way to tackle the health effects of recession and enhance the prospects of recovery, particularly for the most vulnerable groups.

The focus on training and employment is appropriate, as is the work being done to maintain and improve the health of those in work, but too often the schemes in place are getting people ready for jobs which do not exist.

A public health approach to workplace health extends far beyond occupational health services. Worklessness is a major factor in unhealthy behaviour and if public health can play a part in influencing employment and growth then significant health outcomes will be achieved.

A wide range of partnerships is needed in Cumbria including, for example, engagement with the Local Enterprise Partnership to ensure that economic considerations to not ignore health impacts. This cross fertilisation at high partnership level will ensure a more holistic response to community need.

Health services should pay close attention to the employment status of patients and support them to stay in and return to work. This means GPs and other clinicians actively engaging in return to work planning and fully integrating services such as the Condition Management Programme into NHS services for people with long-term conditions.

Although there are clear cost savings to employers from improving employee health, the small businesses that provide many of the low income and low skill jobs will often not have the capacity to provide occupational health support for their employees. The public sector needs to develop models to incentivise and support healthy work environments amongst these small employers with support from public health professionals.

Recommendations:

Research from the 1980s indicates that there is a long period from the time of an economic recession to the major impacts on people's health. The most immediate threat is to people's mental health – with sharp rises in cases of stress, anxiety and depression. Therefore people need to be equipped with the skills to cope with these pressures. The Public Health Outcomes Framework, which is being introduced, gives us the opportunity to think in a more rounded way about the skills which people need to develop to become more resilient.

The effects of the recession on unemployment are predicted to continue in Cumbria for some time after the economy begins to grow nationally. Local action is needed to mitigate the long-term effects of the recession, making it easier for people who are disadvantaged to obtain and keep work, whilst improving the quality of jobs across the labour market. To support this, I recommend that:

- The system of partnership working in Cumbria is properly linked up so that the work of the Health and Wellbeing Board is well connected to the Local Enterprise Partnership and the Safer and Stronger Communities agenda, with employment a standing agenda item for discussion.
- There should be a forum or mechanism for clear dialogue to be held with energy providers about the effects of high fuel prices on health.
- Health services should be fully involved in return to work initiatives.
- The Workplace Wellbeing Charter as the means to maintain and improve employee health should be promoted.
- Services and voluntary initiatives for those suffering from stress, depression or anxiety should be further developed.

Section 4_

Older adults and sensory loss

We have an aging population, and in Cumbria this is a particular issue due in part to the county being a popular retirement destination. Whilst the number of premature deaths from chronic disease is likely to decline in the future due to advances is medical treatment and early diagnosis, the numbers of people living with long-term conditions and disability linked to sensory loss is likely to increase considerably. Therefore this chapter looks at aging and sensory loss, its impact on quality of life, and what can be done to support people who experience sensory loss.

There are a number of health issues associated with aging, yet sensory loss will – to some extent – affect us all as we age. Shakespeare's speech from 'As you Like It', that catalogues the seven stages of a man's life, sometimes referred to as the seven ages of man: infant, schoolboy, lover, soldier, justice, pantaloon, and second childhood, "sans teeth, sans eyes, sans taste, sans everything", highlights that deterioration is an inevitable part of the aging process. It is one of Shakespeare's most frequently-quoted passages.

Sensory loss is a major public health issue that has a serious impact on people's quality of life.

What is sensory loss?

Sensation is the physical and mental process that allows us to receive information from our environment through our five sense organs: eyes, ears, skin, tongue, and nose. Key sensing processes are our sight, hearing, touch, taste and smell.

Sensory loss is the decreased ability to respond to stimuli that affect our senses. For example, vision loss might mean that the print in a newspaper becomes blurred and harder to read, or hearing loss might result in us struggling to hear people speaking or conversation on the television or radio.

The terms "sensory loss" or "sensory impairment" are very general descriptions for a range in conditions covering hearing and sight loss, including people who experience a combination of them both, i.e. "dual sensory loss".

Sensory changes do not occur at the same age for each person, nor do all changes occur to everyone or to the same degree, yet change is an unavoidable part of the ageing process.

Studies have shown changes accelerate at these approximate age ranges:

Hearing – mid 40s

Vision – mid 50s

Touch – mid 50s

Taste – mid 60s

Smell – mid 70s

Around 80% of people over the age of 60 have a visual impairment, about 75% have a hearing impairment and 22% have both limitations.

Sensory loss in Cumbria

There are estimated to be nearly 9,000 older people with a moderate or severe visual impairment in Cumbria in 2010. This number is forecast to increase to 14,498 by 2030 (a 61% increase) with most of the increase among people aged 75 and over. The forecasted numbers is higher than the registered number of people who are registered as blind or partially sighted in Cumbria.

The number of people aged 75 years and over who are registered as blind or partially sighted in Cumbria was estimated to be just over 3,000 in 2010 and is forecast to increase to 5,344 by 2030; a 78% increase. Loss of sight among older people tends to be gradual but can still have devastating effects on quality of life that are very difficult to overcome.

Just over 44,000 people aged 65 and over are estimated to have a moderate or severe, or profound hearing impairment in Cumbria in 2010, forecast to increase by 69% in the next 20 years to 74,517 people. The largest age group with this level of hearing impairment will continue to be those aged 75 to 84 years with more than 34,500 people experiencing this level of disability. Registers of deaf people are inevitably inaccurate and that there is a usual tendency to underestimate the numbers. According to LINK 150,000 UK residents live with the effects of acquired total deafness.

Types of Sensory Loss

Conditions that affect the eyes
Age Related Macular Degeneration
Macular degeneration is an eye condition that affects a tiny part of the retina at the back of the eye, which is called the macula. People with the disease are grouped into:

- Dry macula degeneration (also known as non-neovascular) affects the eye gradually.
- Wet macular degeneration (also known as neovascular) can develop very quickly, and is more serious that dry macular degeneration.

Macular degeneration causes problems with central vision, but does not lead to total loss of sight and is not painful. Macular degeneration most commonly affects people who are over 50, and is often referred to as age related macular degeneration. Around 30% of people who are over 75 have early signs of age related macular degeneration and about 7% have more advanced age related macular degeneration. Approximately 90% of cases of macular degeneration are dry.

The exact cause of macular degeneration is not known. However things are thought to increase a person's chances of developing it:

- Age: macular degeneration develops as people grow older and is most often seen in people over the age of 65
- Gender: more women have age related macular degeneration than men, this may be due to the women have a longer life expectancy than males
- Genetics: some genes have been identified which seem to be linked to the development of macular degeneration in some people
- Smoking: smoking greatly increases your risk of developing macular degeneration.
- Sunlight: if you are exposed to lots of sunlight during your life time, your risk of developing macular degeneration may be increased
- Diet: a number of studies have looked at diet as a risk factor for developing macular degeneration. However, as yet there is not clarity as to the extent to which diet is a factor. There is some evidence that vitamins A, C, E and zinc may help to slow the progression in people who already have developed the condition
- Alcohol: some studies suggest that drinking more than four units of alcohol a day may increase your risk of early macular degeneration.

Cataracts

Cataracts are a very common eye condition. As we become older the lens inside our eye gradually changes and becomes less transparent. A lens that has turned misty or cloudy is said to have a cataract. Cataracts can be caused by a number of things, but by far the most common reason is growing older. In the UK, it is estimated that more than half of people who are over 65 have some cataract development in one or both eyes. Research suggests that some factors my increase the risk of people of developing are-related cataracts. These include:

- A history of cataracts in your family
- Smoking
- Lifestyle factors such as diet
- Overexposing your eyes to sunlight
- Taking steroid medicines for a sustained period

Diabetic Retinopathy

Diabetic retinopathy is a common complication of diabetes. It occurs when high blood sugar levels damage the cells at the back of the eye, known as the retina. Over the course of many years, the blood vessels can be damaged by high blood sugar levels that may be present in people with If it is not treated it can lead to blindness. In the UK in 2010 it was estimated that 40,982 were partially sighted from diabetic retinopathy and 24,976 blind. In 2020 it is predicted that 46,473 people will be partially sighted due to diabetic retinopathy and an additional 29,957 to be blind. There are approximately 12,920 people in Cumbria ages over 65 with diabetes.

Several risk factors increase your risk of developing diabetic retinopathy:

- Length of time you have diabetes: around 90% of people with type 1 diabetes will have some degree of retinopathy after ten years of having diabetes symptoms. For people with type 2 diabetes who need to take insulin, about 79% will have some degree of retinopathy after ten years of having diabetes symptoms.
- Blood Glucose Levels: small changes in blood glucose levels can significantly affect a person's risk of developing retinopathy
- High Blood Pressure: if you have diabetes and a high blood pressure, your risk of developing advanced retinopathy is increased.

Glaucoma

Glaucoma is a term that describes a group of eye conditions that affect vision. Glaucoma often affects both eyes, usually in varying degrees. One eye may develop glaucoma quicker than the other. If left untreated, glaucoma can cause blindness. But if it is diagnosed and treated early enough, further damage to vision can be prevented.

In England, about 480,000 people have chronic open-angle glaucoma. Around 1 in 50 people above 40 years old and 1 in 10 people above 75 years old has chronic open-angle glaucoma. It may be more common among people of black-African or black-Caribbean origins. The other types of glaucoma are much less common. Among white people, acute angle-closure glaucoma may affect about 1 in 1,000 people. It is more common among people of Asian origin, affecting around 1 in 100.

There are various factors that can increase your risk of developing glaucoma, including:

- Age: In the UK, chronic open-angle glaucoma affects 1 to 2 people in every 100 who are over 40 years old, and 4 to 5 people in every 100 who are over 80 years old
- Ethnic origin: people of African or Afro-Caribbean origin are at increased risk of developing chronic open-angle glaucoma. People of Asian origin are at increased risk of developing acute angle-closure glaucoma
- Short sightedness (myopia): people who are short-sighted are more likely to develop chronic open-angle glaucoma
- Ocular hypertension (raised pressure in the eye): people with ocular hypertension are at increased risk of developing chronic open-angle glaucoma
- Family history: people with a close relative, such as a parent, brother or sister who has glaucoma, are at increased risk of developing the condition
- Medical history: people with diabetes, which is a condition caused by too much glucose in the blood, may be at increased risk of developing glaucoma.

Conditions that affect hearing

Age and loud noises are the most common causes of hearing impairment.

Age-related hearing loss (Presbycusis)

Age is the biggest single cause of hearing impairment. Most people begin to lose a small amount of their hearing when they are 30 to 40 years old. This hearing loss increases as you become older. By the age of 80 most people will have significant hearing impairment. Hearing impairment that develops as a result of getting older is often known as age-related hearing loss or presbycusis.

Age-related hearing loss occurs when the sensitive hair cells inside the cochlea gradually become damaged or die. As your hearing starts to deteriorate, high-frequency sounds, such as female or children's voices, may become difficult to hear. It may also be harder to hear consonants, such as the letters s, t, k, p and f. This can make understanding speech in background noise very difficult.

Dual Sensory Loss

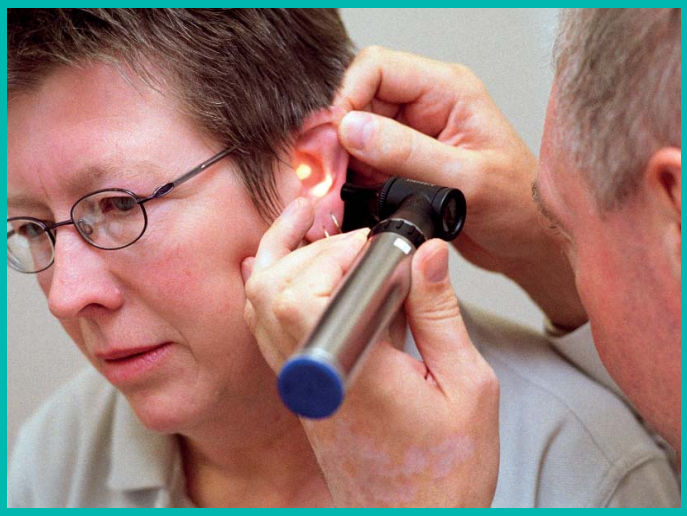
Many deafblind people are not known to their local social services authority. Of those who are in contact with social services, not all are identified as having dual sensory impairment nor are they in receipt of appropriate services. This applies to both adults and children. SENSE, a national charity that supports and campaigns for children and adults who are deafblind, estimates that 4.6% of over 75s, or almost 1 in 20, are sufficiently impaired to be considered deafblind.

Local Service Provision

Rehabilitation services for people with sight problems are provided by Cumbria County Council through a specialist ROVI (rehabilitation officers for the visually impaired) service. ROVIs are all trained to work with sensory loss and are able to communicate by using the deafblind manual. This offers a specialist assessment and offers assistance with daily living, communication, orientation and mobility. The service also accepts referrals in and makes referrals out to the reablement service run by Cumbria County Council and signposts to relevant services in both statutory and voluntary sectors.

Primary care services are provided by opticians, optometrists and GPs. Low Vision clinics are funded by NHS Cumbria and include services provided by opticians and orthoptists, rehabilitation officers from the County Council and staff from local blind societies/sight support organisations such as Cumbria Societies for the Blind.

Secondary eye care services are provided by hospitals in Cumbria, with some specialisms being provided outside of the County. There are no Eye Care Liaison Officer (ECLO) posts in Cumbria, which elsewhere in the country ensure that emotional support, advice and information are provided at the point of diagnosis in hospital, but local blind societies and sight support organisations support some clinics.



Many people with dual sensory loss are reliant on family and friends to provide day to day support and interpreting services for them. This creates a dependency that lowers an individual's confidence and self-esteem. DeafVision runs a service that has direct link with access to information about health issues. Some support includes providing communication support using sign language interpreters, lip speakers and note takers for deaf people using health services. In September 2007, Cumbria County Council Adult Social Care Directorate commissioned and published a "Cumbria Dual Sensory Loss Review", which investigated the experiences and needs of deafblind people living in Cumbria. One of the six recommendations was the need to develop a one to one Communicator Guide scheme for people with dual sensory loss, to ensure that they are able to access specifically trained one to one support workers.

DeafVision have a project that is currently in its third year (funded by BBC Children in Need) to run educational and recreational activities where deaf children from across Cumbria meet up and experience peer support, confidence building and to look for reduction in experiencing isolation. The project also provides opportunities for parents/carers of deaf people to meet up and to exchange experiences.

The UK Vision Strategy seeks a major transformation in the UKs eye health, eye care and sight loss services. NHS Cumbria, Cumbria County Council and Cumbria's voluntary sector organisations have worked together to produce

a strategy which takes the UK Vision Strategy into account. The strategy identifies the following priority outcomes:

Improve the eye health of people in Cumbria:

- Eliminating avoidable sight loss and delivering excellent support for people with sight loss
- Inclusion participation and independence for people with sight loss

Prevention and Early Intervention

Poor eyesight, due to cataracts or macular degeneration, and loss of hearing can greatly hinder older people in their daily lives, but if diagnosed at an early stage and treated the impact can be reduced. Examining and reviewing older people's vision through regular sight and hearing tests to ensure that spectacles and hearing aids are appropriate can also help to limit the extent of these common impairments.

It is estimated that over 50% of sight loss can be avoided; however 4 in 10 people do not have their eyes checked by an optometrist on a regular basis. With the rising numbers of older people in Cumbria and particularly the rising numbers of very elderly people predicted between now and 2030, the number of people with sight loss will rise substantially if no action is taken. There will be an increased level of need for hearing tests and aids across the county in the future as the population ages.

As well as early intervention we must also consider prevention. There is a correlation between smoking and visual loss. Studies have shown that people who smoke are three or four times more likely to have Age Related Macular Degeneration (AMD). There is also growing evidence that suggests that a good diet can help to improve the health of our eyes. Research has suggested a link between AMD and a diet high in saturated fat. There is also evidence that eating fresh fruits and dark green, leafy vegetables – foods rich in vitamins C and E, selenium, and carotenoids (including beta-carotene, lutein and zeaxanthin) – may delay or reduce the severity of AMD.

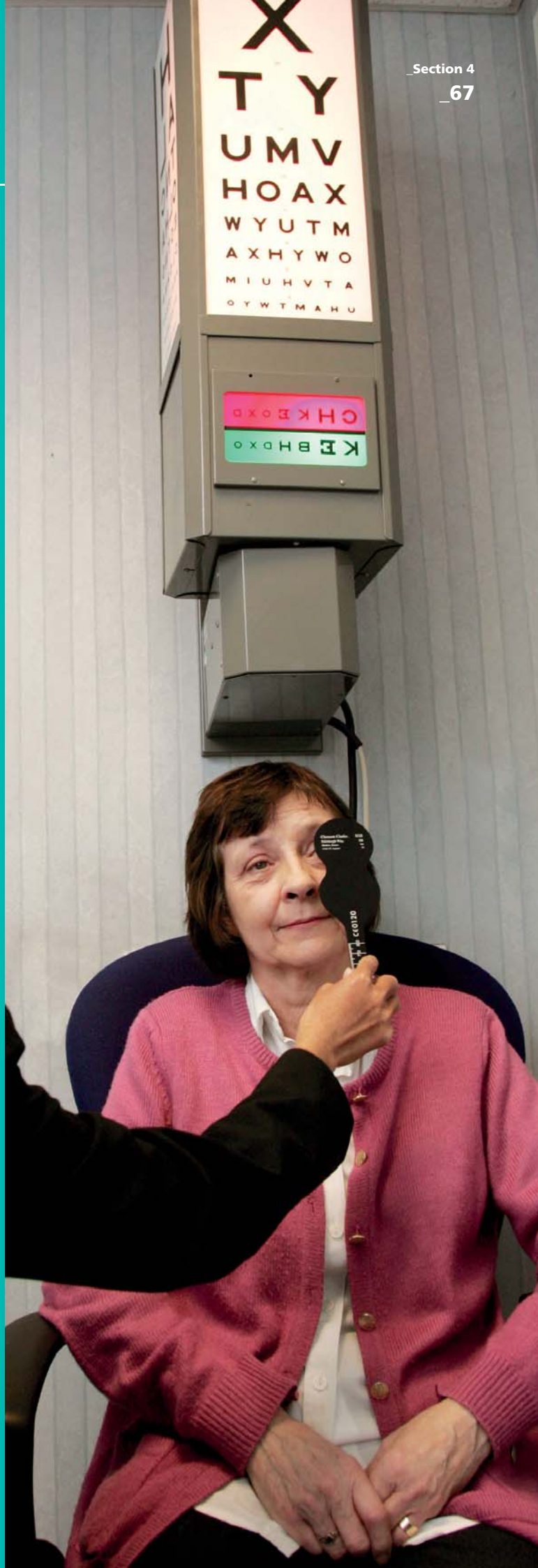
Whilst we must try to correct hearing impairments when it becomes established, we also need to try to prevent hearing loss. Noise induced hearing impairment is preventable. Being exposed to loud noise over and over is one of the most common causes of permanent hearing loss. People can be exposed to harmful avoidable noises at work, home, night clubs, concerts or other settings. Hearing loss usually develops slowly and without pain or other symptoms, and you may not notice that you have hearing loss until it is severe. Steps can be done to help to prevent this damage through using hearing protection at work, controlling the volume on personal stereos and MP3 players and protecting ourselves from harmful noises.

Recommendations:

Cumbria has a rapidly ageing population, one that is ageing at a faster rate than the rest of the UK. As we age, sensory loss will, to some extent, affect is all, yet there are a number of actions that can be taken to limit the negative effects. In addition, although biological changes to our eyes and ears are part of growing older, the impact can be reduced through, for example, regular sight and hearing tests.

I recommend:

- More work needs to be done to ensure we fully understand the size of the problem in order to commission services to support sensory loss in the future.
- Raise awareness of the importance of uptake of regular sight and hearing tests – particularly for those at greatest risk.
- Include the dangers of sight loss as part of campaigns about smoking, diabetes and obesity.
- Ensure that those with newly diagnosed sight loss have immediate access to help to retain independence through liaison with support and voluntary services at hospital eye clinics.
- Deaf awareness training for employers and employers encouraging staff to have their ears checked to encourage early diagnosis.
- People with a sensory impairment can struggle to access services, advice and information. Therefore they should be promoted among people with a sensory impairment, and to their families and carers.
- Ensure that services and information are accessible to all, particularly those who suffer from hearing or sight difficulties.
- Develop commissioning models that ensure that services accurately identify and respond to the needs of people with sensory impairment, so they are delivered in an integrated, accessible, affordable way and promote independence.



Section 5_

The health of military veterans

In England there is currently estimated to be around 3,771,534 retired Armed Services personnel. In Cumbria, the figure is estimated to be around 43,121. This is the highest in the North West Region. Around 15,000 of these are under the age of 65.

There is no single reason identified as to why we have such a high number of people who have served in the Armed Forces; however it is recognised that recruitment to the forces is influenced by the performance of the economy and is easier in times of high unemployment.

Historically, areas of Cumbria have suffered from the closure of several local industries and this may account for the high levels of recruitment to the forces in our county.

The Armed Forces Covenant highlights the responsibility our servicemen and women have in relation to the defence of the realm. The Covenant recognises that this duty means servicemen and women sacrifice some civilian freedoms, may face danger and sometimes suffer serious injury or death in the line of duty. The Covenant also recognises the obligation society has to those who have served in the past and to their families, stating that they should face no disadvantage compared to the rest of the population in relation to accessing services.

In relation to healthcare, this means that military veterans, who have a condition relating to their time in service in the Armed Forces, should receive priority treatment, subject to clinical need.

Previous studies have found that ex-military personnel have similar health problems to the general population. However alcohol problems, depression and anxiety disorders are identified as issues for veterans. Arthritis is also an issue and is seen to be more prevalent and more severe in this section of the population.

Those people who leave the military with psychiatric problems are recognised at being at an increased risk of social exclusion and ongoing ill health. (Fear et al 2009)

Veterans who have received injuries during their time in conflict may need longer term care and support upon leaving the armed forces. Ex-servicemen and women also report the additional problem of not knowing where to go to access help.

Cumbria Partnership NHS Foundation Trust, through its First Step service, aims to improve access to psychological therapies and provide rapid access to evidence based treatments for military veterans with common mental health problems. Conditions such as depression, anxiety, post traumatic stress disorder and panic disorder can be treated through the programme. Veterans can self-refer to the First Step service where they will be assessed and the most appropriate treatment provided.

NHS Cumbria recognises the debt we owe to our ex-servicemen and women. We are currently conducting a Health Needs Assessment of ex-military personnel living in Cumbria. Our Health Needs Assessment will be targeting those veterans involved in conflict post 1970. This will cover veterans who have served in Northern Ireland, the Falkland Islands, the Gulf Wars, the Iraq Conflict and Afghanistan.

Our findings should enable us to recommend actions which will allow any unmet health needs of veterans to be addressed.


NHS
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Section 6_

Review of last year's recommendations

The Annual Public Health Report 2011 focused on health protection and resilience, and reviewed a number of topics from infection prevention and screening programmes, to injury and violence and sustainable energy.

A number of recommendations were made to build on the resilience of our communities and make policy changes to help ensure that Cumbria continues to strengthen our health protection role and emergency response. At the time of writing there are still some uncertainties about the division of responsibilities between Public Health England and local Public Health Teams; however below I provide a brief update on the progress made to achieve the recommendations that were made in 2011.

Section One. Emergency Planning:

Public sector organisation in Cumbria work extremely well together in an emergency, yet in order to further strengthen emergency planning procedures in Cumbria, I recommended:

- Still closer collaboration between partner agencies both during emergencies and in the ongoing planning process - as agencies feel the effects of reductions in resources over the next few years we need to work together even more closely to maintain a coordinated and effective response.

  NHS Cumbria and Public Health Cumbria continue to play an active part in the multi-agency Cumbria Resilience Forum and participate in emergency exercises on a regular basis. Plans are in place for the Cumbria Health Protection Team to co-locate with Local Authority colleagues in the new Cumbria Control Centre which is under construction.

- An increased focus on developing resilience at community level - for effective and rapid response to emergencies, especially in a rural area such as ours, it is essential to build community resilience and understand what action to take in an emergency.

  Several areas have very active Flood Action Groups and we are working with colleagues in the County Council Resilience Unit to help develop these groups to provide community resilience to other emergency situations. In addition we continue to support the network of Community First Responders, who are a group of volunteers trained to attend emergency calls received by the ambulance service and provide care until the ambulance arrives. The new Cumbria Resilience Plan has embraced public engagement as an important part of emergency preparedness, building on our experiences of the Cumbria floods where members of the public played a critical role in response and recovery.

- Work with third sector organisations to provide basic first aid training to our communities - it is unacceptable that people die needlessly because no one could give them first aid. If everyone was able to learn some basic life saving and resilience skills lives could be saved.

  Two members of the Cumbria Health Protection Team are actively involved with St John Ambulance Cumbria, and these links are being used to implement community first aid training through St John's 'Make the Difference' campaign which hopes to give free first aid training to local communities. Research carried out on behalf of St John Ambulance has shown that 25% of the population would do nothing in an emergency and 58% would not feel confident trying to save a life, this is not acceptable.

Section Two. Infection Prevention:

Reducing the number of reports of infections can only be achieved with everyone working together in our hospitals and health care settings and the wider community. To further continue downward trends in infection, I recommended:

- Priority should be given to ensuring that infection prevention services remain robust through the current round of NHS reorganisation.

  The move of provider services to Cumbria Partnership NHS Foundation Trust has enabled that organisation to further develop its in-house infection prevention team. There is now an opportunity for the partnership trust to develop its public health work to the benefit of the whole health system in Cumbria.

- Following on from the implementation of Clinical Commissioning Groups, this aspect of public health should become mainstreamed within primary care.

  Changes to provider services has created capacity in Public Health Cumbria to work more closely with independent providers of care, such as nursing and residential homes, and with primary care medical and dental practices. We continue to work closely with acute trust colleagues and, through our colleagues in Communications, with the media to inform the public about the importance of infection prevention.

Section Three. Vaccination:

In order to continue to see a decline in preventable illness, and ensure a high uptake of available vaccines, I recommended that:

- We continue to promote the importance of vaccinations, by ensuring our staff pass on accurate information on the importance of vaccinations at all appropriate opportunities.

  The importance of taking up vaccine opportunities is regularly featured in local media and communications campaigns. In the event of a particular vaccine being featured in the media in a negative way, there is a proactive response to ensure that front line staff are armed with accurate and up to date information to pass on to patients and other colleagues. Cumbria continues to have some of the best vaccine uptake rates, for example 95.5% of children receive the MMR vaccine by their second birthday, compared to 90.7 across England.

- We continue to ensure that all staff delivering vaccinations are trained to the highest level and regularly updated.

  There are comprehensive arrangements for staff training and updating. These sessions are delivered mostly on a face-to-face basis but e-learning has also become an important tool.

- We endeavour to be as flexible as possible in our delivery of vaccination programmes to ensure they are accessible to all that require them.

  Vaccinations are offered in a variety of settings as appropriate. Pre-school children mostly receive vaccines in primary care with school age children being offered vaccines through the school nurses. However in order to increase the opportunity for vaccination, immunisations are offered flexibly where appropriate. For example in order to raise MMR uptake in Barrow, special sessions were arranged in community settings.

- We continue to offer advice and support to anyone with concerns about vaccinations.

  Our Vaccination Coordinator frequently speaks to patients directly regarding vaccination queries and concerns. In addition, advice and support is offered to other health professionals dealing with these concerns. With colleagues in Communications, we are developing a Health Protection website on the internet as part of the new Public Health arrangements. This will feature up to date links and information for members of the public and health professionals.

- We continue to encourage good uptake in vaccinations in as many ways as we can, to enable us to reach the required levels of vaccine uptake to protect the population, [especially those who are not able to be vaccinated].

  We continually promote the importance of protection through vaccination, through the media, schools and health settings.

Section Four. Screening Programmes:

As we become older, we are more likely to develop a range of conditions that are rare in younger people. Therefore it is vital that people in Cumbria are aware of the value of screening programmes and take up the opportunity for screening when offered. Screening tests are never 100% accurate and it is important to be aware of changes in our body, for example breast lumps, or a change in bowel habit, and seek medical advice if worried. There are a number of potential areas for improvement and greater assurance of quality across each of the screening programmes, as evidenced in the 2010/11 service failure of breast screening in North Cumbria.

To continue to improve early detection rates and screening programme uptake in Cumbria, I recommended that:

- Communications specialists and health promotion practitioners work together to deliver campaigns that highlight the importance of screening programmes for targeted groups in the region.

  We work with colleagues in these areas at all times to ensure that there is a steady output to the public regarding screening programmes. Recent campaigns include a 'Be Clear on Cancer' campaign to highlight the signs of bowel cancer, and a 'Cough, Cough' campaign that focused on the symptoms and early detection of lung cancer.

- People in Cumbria take up the opportunity for screening when invited, and encourage friends and relatives to do the same.

  The importance of taking part in regular health screening is regularly raised in the media, and health staff are encourages to remind their patients of the importance of screening for early detection of ill health or to identify those members of the community who may be at greater risk of developing certain conditions.

- People must always be alert to changes in their bodies that could potentially be signs of illness, so women should still be on the lookout for changes in their breasts even if they have recently had a screening test, and people should still report a change in bowel habit or bleeding even if they have recently had a bowel screen.

  Cumbria is participating in some national high profile media campaigns to continue to raise the importance of early warning signs and symptoms of illness, encouraging members of the community to present early to the GP with any problems.

Section Five. Injury and Violence:

The subject of injury and violence covers a wide number of public health issues, and requires a coordinated, multi-agency effort to tackle some of the prevailing issues.
I recommended that:

- Work should continue to improve our understanding of injury and violence in Cumbria, and especially of threats to health in agricultural communities in order to produce a more effective approach to prevention.

  We continue to work with Liverpool John Moores University to improve our data systems for recording injuries caused by violence. A recent successful event was held to promote awareness and the increased use of shatterproof glasses by the licensed trade. We are progressing plans with Sedbergh Medical Practice to develop it into a research centre where we can study patterns of injury in a rural area. The new Safer Cumbria Group, which has replaced the Safer and Stronger Thematic Partnership, will become an important focus for injury and violence prevention, and the election of a Police and Crime Commissioner in November will provide an opportunity to raise the profile of this work. The links between the Safer Cumbria Group and the Board of Health and Wellbeing should be developed.

Section Six. Healthy Workplace:

Individuals have a fundamental personal responsibility to maintain their own health. Occupational health has traditionally never been part of the NHS, other than for its own employees, yet with many employers to date having failed to provide access to adequate occupational health, and the associated costs to the taxpayer and the economy being so substantial, there is a strong case for a county wide service in Cumbria.

Ultimately, no efforts from employers or health care professionals will be effective unless individuals actively seek to remain in or return to work and do not assume that being signed off work with a health condition is always necessary or beneficial, yet in order to ensure a coordinated effort to improve workplace health, I recommended that:

- NHS Cumbria should continue to develop its involvement in the provision of work-related health interventions and occupational health services, to ensure a holistic approach to occupational health that supports both those in work, and those seeking work.

  We continue to support employers with their healthy workplace initiatives and develop a systematic approach to work and worklessness health issues.

Section Seven. Health Protection and Hard To Reach Groups:

In addition to the specific recommendations for Gypsies and Travellers, the challenge for the NHS in Cumbria is to eradicate the health divide and level out inequalities. Increasingly Public Health Cumbria is working with partner agencies to tackle many of the problems that impact on health, yet in order to further engage with hard-to reach groups, I recommended that:

- Public Health Cumbria continues to devise campaigns to reach hard to reach groups and increase uptake of screening and vaccinations.

  The Gypsies and Travellers Health Group continues to flourish and we have a regular presence at the Appleby Horse Fair to engage our resident gypsy population in health issues.

- We work with HMP Haverigg to implement the findings of the health needs assessment and so improve the health of prisoners. Some of the areas that require attention are screening programmes, smoking and diet.

  We continue to work closely with HMP Haverigg to implement the needs assessment.

Section Eight. Sustainable Energy:

The interdependence of human health and wellbeing on the environment is becoming clearer as we grapple with the issues of sustainability and global warming. How we use energy, and shape our human habitats in the form of our towns and villages and how we live, work, play and move around within and between them is likely to become an increasing matter of concern as we progress through this decade.

To further prepare for changes to our climate, I recommended that:

- Public Health Cumbria should seek to support increasing understanding of these issues so that it can play a full part in shaping the policy options in the years to come.

  We engage, and will continue to engage, in all consultation exercises relating to new power installations (including nuclear) in Cumbria. We recently produced a report summarising the research around long-term effects of the nuclear industry on public health to help to inform this debate.

- We work with communications experts to promote awareness raising campaigns such as ensuring homes are prepared for winter, at risk groups receive a seasonal flu vaccine, being a good-neighbour to ensure that our more vulnerable members of society are cared for.

  We have coordinated plans for the winter which incorporate all these elements. These campaigns are delivered by our colleagues in Communications.

Section 7_

Recommendations in the 2012 Public Health Report

To improve health outcomes in Cumbria, I recommend:

Childhood Epilepsy

1. A review of current service provision and community assets should take place to inform the development of an integrated epilepsy care pathway.
2. Development of nursing expertise in child epilepsy care, to ensure coordination of care pathways across primary and secondary care, family support, patient education and a link to school health services.
3. The development of an epilepsy network to share best practice on epilepsy care to help improve seizure control and support clinical decision making about the need for admission.
4. A review into the transition of children with epilepsy from paediatric to adult epilepsy services.

Working age adults and the impact of the economic recession

5. The system of partnership working in Cumbria is properly linked up so that the work of the Health and Wellbeing Board is well connected to the Local Enterprise Partnership and the Safer and Stronger Communities agenda, with employment a standing agenda item for discussion.
6. There should be a forum or mechanism for clear dialogue to be held with energy providers about the effects of high fuel prices on health.
7. Health services should be fully involved in return to work initiatives.
8. The Workplace Wellbeing Charter as the means to maintain and improve employee health should be promoted.
9. Services and voluntary initiatives for those suffering from stress, depression or anxiety should be further developed.

Older adults and sensory loss

10. More work needs to be done to ensure we fully understand the size of the problem in order to commission services to support sensory loss in the future.
11. Raise awareness of the importance of uptake of regular sight and hearing tests – particularly for those at greatest risk.
12. Include the dangers of sight loss as part of campaigns about smoking, diabetes and obesity.
13. Ensure that those with newly diagnosed sight loss have immediate access to help to retain independence through liaison with support and voluntary services at hospital eye clinics.
14. Deaf awareness training for employers and employers encouraging staff to have their ears checked to encourage early diagnosis.
15. People with a sensory impairment can struggle to access services, advice and information. Therefore they should be promoted among people with a sensory impairment, and to their families and carers.
16. Ensure that services and information are accessible to all, particularly those who suffer from hearing or sight difficulties.
17. Develop commissioning models that ensure that services accurately identify and respond to the needs of people with sensory impairment, so they are delivered in an integrated, accessible, affordable way and promote independence.

Section 8_ End word

Bearing in mind the scope and contents of this year's annual report, and the political and organisational context in which I am writing it, it has become clear that there is a need for a new settlement for public health and the related efforts of Cumbrian society to improve and protect the wellbeing of Cumbrian citizens. Squaring the circle at a time of demographic challenge, increases in technical possibilities and public expectations together with diminishing resources requires a shift from a paternalistic model. This model, in which clients or patients are "fixed" by professionals with unique skills, has served us well, yet a shift is needed - to a model of co-production in which the dissemination of knowledge and expertise across the population becomes a leading principle.

In such a 21st Century model, a health literate population will manage many more common conditions for itself, supported by a variety of different resources in the community including teachers, pharmacies, fitness instructors and good neighbours. A great deal of the burden of preventable ill health will be prevented, there will be more appropriate use of services to reduce demand so that health services are freed up to respond in an optimal way to those in greatest need. Increasingly, those with long term conditions will become expert patients, managing their condition for themselves, but with professional support. A community wide debate on end of life care will also result in a big shift towards quality home death in place of the present unsatisfactory domination of mechanistic hospital death often lacking a humanistic context.

In this year's report we have focused on two topics involving long term conditions; epilepsy, which is an age old problem but remains a challenge, and the increasing issue of age related loss of the special senses.
Our ability to respond to challenges such as this will be a test of the arrangements which we craft together over the coming years.

I also focus the report on problems arising from worklessness, where contention is that we should endeavour to prevent a recurrence of the impact of the economic distress in the 1980s, the legacy of which we are still to some extent living, with for example the problem of illegal drugs.

I flag up emerging concerns about the wellbeing of those citizens who have served the armed forces, whose health and wellbeing is suffering as a consequence. I will return to this topic next year.

All areas of the public sector are facing the challenge of delivering the same or more with far fewer resources. By making improvements described throughout this report we are striving to achieve three key public health objectives: reducing health inequalities, improving the quality and outcomes of the services we provide and making best use of resources to add years to life and life to years.

It is my privilege to be in post at the time of the return of public health to its Local Authority roots; however it is clear that in contrast to the Victorian age of great men as leaders, the task of improving public health in the future is a shared one.


MONDAY
Happy

Section 9_

Final word: A healthy outlook

We know that more lives could be improved if there was a greater emphasis on helping people to stay healthier for longer and being equipped with the skills to make the right health choices. Self care is an integral part of daily life. It involves taking responsibility for your health and wellbeing and includes what you do every day to stay fit and maintain good physical and mental health. Self care can prevent illness or accidents and also includes understanding how to care for minor ailments and long-term conditions. People with long-term conditions can benefit enormously from being supported to self care. They can live longer, have less pain, anxiety, depression and fatigue, have a better quality of life and be more active and independent. In Cumbria, we seek to support patients to be their own health expert.

There are a number of ways that you can help yourself to stay healthy. Even small changes can improve your health and cut your risk of illness. Here are our top tips:

Stopping smoking

Smoking is the single biggest avoidable cause of premature death in Cumbria. On average each year in Cumbria, over 900 people die because they smoke. Smoking is linked not only with lung cancer; it is also a significant risk other cancers and can lead to deaths from chronic obstructive pulmonary disease, pneumonia, heart disease and stroke. Quitting isn't easy but with support you are four times more likely to succeed. For advice and support to stop smoking, call the Cumbria Stop Smoking Service on 01900 324222 or text QUIT to 82450.

Maintaining a healthy weight

Being overweight can increase your risk of developing some cancers, heart disease and stroke. A healthy diet and regular exercise will help to maintain a healthy weight. If you are concerned about your weight, your GP can provide you with information and support to find a healthy weight for you.

Limit your alcohol intake

Every year around 94 people die of alcohol related conditions across Cumbria, yet negative effects can begin as soon as you start drinking above the recommended levels. People who regularly drink over recommended limits or drink excessively in one sitting, could experience short term health effects such as anxiety or sexual dysfunction and place themselves at risk of developing longer term health problems such as liver disease, depression or some cancers.

Department of Health Guidance state that men should not regularly exceed three to four units a day and women two to three units. One unit is approximately half a pint of normal strength lager, a small glass of wine (125ml) or a 25ml spirit measure. Limiting your alcohol intake will also help to keep your weight down.

Keep active

Taking regular exercise is essential to keeping your weight down and your body strong. Find something you enjoy - this could be walking, swimming or even dancing or gardening which are all excellent forms of moderate activity. Try to aim for 30 minutes a day of exercise that leaves you slightly out of breath but still able to hold a conversation. As your fitness increases, you will find that you have to work harder to become out of breath and this in turn will increase your fitness level. Exercising regularly can increase the strength of your bones, relieve stress and reduce fatigue.

Eat a balanced diet

Make sure you eat a wide range of foods to help you obtain the nutrients you need to stay physically and mentally fit. Try to eat at least five portions of fruit and vegetables each day and try to eat fresh produce rather than processed food. Avoid foods that are high in fat, salt or sugar. A healthy diet and regular exercise will help you to maintain a healthy weight.

Look after your mental health

Being mentally fit is as important as being physically fit, to reduce the risk of illness. Everyone becomes stressed from time to time, but prolonged stress can have some long- term effects on your body, such as insomnia or depression and high blood pressure which is a cause of stroke and heart attacks. To manage stress, take time out to relax and do things you enjoy. Talking with close friends and family and enjoying a balanced diet can also help. If your self help techniques are not working for you, and stress if affecting your daily life, make an appointment to see your GP.

Stay safe in the sun

Skin cancer is one of the most common cancers in the UK and the number of people who develop it is increasing. Keep an eye out for changes to your skin and report these to your doctor without delay. Skin cancer, like all cancers, is much easier to treat if it is found early. Protect your skin by keeping your exposure to sun to a minimum and using a sunscreen with a sun protection factor (SPF) of at least 15. The higher the SPF, the better. Go for sunscreens which protect against harmful UVA and UVB rays. Stay out of the sun when the sun is at its highest, usually between 11am and 3pm, and protect children's delicate skin with long sleeved tops and sun hats.

Look after your smile

Practice good oral hygiene habits by brushing your teeth twice a day with a medium brush and fluoride toothpaste. Avoid sugary foods and drinks. It is important to have regular checkups with your dentist to maintain your oral health.

Look after your sexual health

Using condoms during sex will protect you from most sexually transmitted infections (STIs), including Chlamydia and HIV. If you are concerned about your sexual health, you can speak to your GP in confidence or call Sexual Health Cumbria on 0845 658 3131 for confidential advice on where to go for sexual health screening and treatment.

Understand the importance of screening

Take up the opportunity for screening when invited, and encourage friends and relatives to do the same.

Bowel cancer screening aims to detect bowel cancer at an early stage (in people with no symptoms), when treatment is more likely to be effective. Men and women aged between 60 and 74 are automatically sent a test kit to be completed at home, once every two years.
Breast screening helps detect breast cancer at an early stage. Women aged between 50 and 70 are automatically invited for a free breast x-ray (mammogram) every three years.
Cervical screening is not a test for cancer. It is a way of checking the health of a woman's cervix (the neck of the womb) to prevent cervical cancer. Women aged between 25 and 49 are automatically invited for free cervical screening every three years. Those aged between 50 and 64 are invited every five years.

Indicator guide

Social and Place Wellbeing

1. **% of working age adults with level 4 or greater education:** % of adults aged 16-64 educated to NVQ4 or above, from the Annual Population Survey (APS), January 2010-December 2010.

2. **Fuel Poverty:** % of households that need to spend more than 10% of their income on fuel to maintain a satisfactory heating regime (21 degrees in main living area, 18 degrees in other rooms), Department for Energy and Climate Change, 2009

3. **Excess winter deaths:** % of excess winter deaths (additional deaths during December-March) based on the non winter deaths for the period 11th August 2006- 31st July 2009, from North West Public Health Observatory (NWPHO) Health Profiles.

4. **All benefits claimants:** % of the working age population (16-64) receiving state benefits, NOMIS, August 2011

5. **% of children living in poverty:** the percentage of children aged 0-19 living in families in receipt of out of work benefits or tax credits where their reported income is less than 60% of median income from HM Revenue and Customs, 2009.

6. **% who feel that they belong to their immediate neighbourhood:** from the Cumbria Place Survey Tracker, 2009.

7. **% people who agree they can influence decisions in their area**: from the Cumbria Place Survey Tracker 2009.

Lifestyles and Health Improvement

8. **Estimated smoking prevalence:** percentage of adults aged 18 and over who smoke based on responses to the Office for National Statistics (ONS) Integrated Household Survey, from NWPHO health profiles, 2009-2010.

9. **% of mothers smoking during pregnancy:** number of mothers who smoke at the time of delivery per 100 maternities where smoking status is recorded, from Cumbria Primary Care Trust maternity databases, Q1, Q2 and Q3 2011/12.

10. **Hospital admissions due to alcohol:** Admission episodes for alcohol attributable conditions per 100,000 of the population, DSR, all ages, from Local Alcohol Profiles for England, 2009-2010.

11. **% reporting drunk and rowdy behaviour as a problem:** from the Cumbria Place Survey Tracker 2009.

12. **Estimated prevalence of drug misuse (crack and opiates) per 1000:** crude rate of estimated problem drug users per 1000 of the population aged 15-64, from estimates commissioned by the Home Office, NWPHO Health Profiles, 2008-2009.

13. **% of physically active adults:** the % participating in sport and active recreation, at moderate intensity, for at least 30 minutes on at least 20 days but no more than 28 days in the last 4 weeks (equivalent to at least 5 times a week over the previous month), Active People Survey Five, Sport England, 2010-2011

14. **% children participating in PE:** the percentage of children attending state schools that belong to a school sports partnership who participate in at least 3 hours of high quality PE and school sport within and beyond the curriculum in a typical week of the academic year. From TNS-BMRB PE and Sport Survey, NWPHO Health Profiles, 2009-2010.

15. **Healthy eating among adults:** estimated prevalence those aged 16 and above who consume 5 or more portions of fruit and vegetables per day from responses to the Health Survey for England, NWPHO Health Profiles 2006-2008.

16. **% of year 6 children obese:** percentage of year 6 (aged 10-11) state school pupils classified as obese, from National Child Measurement Programme, 2010-2011 School year.

Health and Wellbeing Status

17. **Mortality from all cancers**: mortality from all cancers, DSR per 100,000 of the population, those aged under 75, from the NHS Information Centre, 2008-2010.

18. **Mortality from all circulatory diseases:** mortality from all circulatory diseases, DSR per 100,000 of the population, those aged under 75, from the NHS Information Centre, 2008-2010.

19. **Hospital admissions for neuroses:** Emergency hospital admissions for neuroses (codes F40-F48), per 100,000 of the population aged 15-74 years, indirectly age and sex standardised rates, NHS Information Centre, 2009-2010

20. **Admissions for deliberate self harm:** emergency hospital admissions for intentional self harm (codesX60-X84), DSR per 100,000 of the population all ages, from Hospital Episode Statistics, NWPHO 2009-2010.

21. **Mortality from suicide and injury undetermined:** mortality from suicide and injury undetermined (codes X60-X84 and Y10-Y34 excluding Y33.9), DSR per 100,000 of the population, all ages, from NHS Information Centre 2008-2010.

22. **Infant mortality per 1000 births:** rate of infant mortality under age one per 1000 live births, NHS Information Centre 2008-2010.

23. **% born with a low birth weight (<2.5kg):** percentage of live and still births where the birth weight was less than 2,500 grams, NHS Information Centre 2010.

24. **Teenage pregnancy rate (aged 15-17):** conception rate per 1000 of the female population aged 15-17, ONS and Department for Education, 2008-2010.

25. **% of working age population with a disability:** percentage of the population aged 16-64 with a disability from the Annual Population Survey, June 2010-July 2011.

26. **% of working age adults with disabilities in employment:** percentage of adults aged 16-64 with disabilities in employment from the Annual Population Survey, June 2010-July 2011.

27. **% of 0-16 entitled to disability living allowance:** based on the numbers claiming disability living allowance from the Annual Population Survey and the ONS 2010 mid year population estimates, February 2011.

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Personal Resilience Guide

Cumbria County Council

NHS Cumbria

Prepare for an Emergency

To prepare for an emergency, you should take time to find out:

- Where and how to turn off water, gas and electricity supplies in your home
- The emergency procedures for your children at school and at your work-place
- How your family will stay in contact in the event of an emergency
- If any elderly or vulnerable neigh-bours might need your help
- How to tune in to your local radio sta-tion
- Fit and maintain smoke alarms in your home and plan an escpare route should a fire break out
- Be aware of important supplies you may need in an emergency such as prescribed medication, candles and spare clothes.

What to do in an Emergency

If you find yourself in the middle of an emergency, your common sense and instincts will usually tell you what to do. However, it is important to:

- Make sure **999** has been called if peo-ple are injured or if there is a threat to life
- Not put yourself or others in danger
- Follow the advice of the emergency services
- Try to remain calm and think before acting, and try to reassure others
- Check for injuries - remember to help yourself before attempting to help others.

If you are not involved in the inci-dent, but are close by or believe you may be in danger, in most cases the advice is:

- Go inside a safe building
- Stay inside until you are advised to do otherwise
- Tune in to local radio or TV for more information.

Of course, there are always going to be particular occasions when you should not "go in" to a building, for example if there is a fire. Otherwise:

GO IN, STAY IN, TUNE IN.

Basic First Aid

Knowing some basic first aid skills could help you deal with an emergency – your relatives or friends could be the ones to bene-fit from your skills.

When there is more than one injured person, go to the qui-etest one first.

They may be unconscious and need immediate attention.

Learning first aid is easy so why not take a few minutes now to familiarise yourself with the first aid scenarios below, or enrol on a basic first aid course.

Unconscious

If the casualty is not respond-ing but is able to breathe normally, turn them onto their side to protect their air-way. If there are no signs of life, call 999 and ask for an ambulance. Follow the call handlers advice on how to give chest compressions and mouth-to-mouth resuscita-tions while you wait for the ambulance to arrive.

Severe bleeding

Control severe bleeding by applying firm pressure to the wound using a clean, dry dressing and raise it above the level of the heart. Lay the person down, reassure them, keep them warm and loosen tight clothing.

Burns

For all burns, cool with water for at least 10 minutes. Wrap the affected part in clingfilm, do not apply dry dressings, keep the patient warm and call an ambulance.

Broken Bones

Try to cause as little move-ment as possible.

Choking

Encourage the casualty to cough if they are able to do so. If not, lean them forward and give up to five sharp blows between the shoulder blades. If this fails, give up to five thrusts in the stomach if you or a bystander have the skills to do this.

Emergency Contact Details

Compile a list of useful emergency contact numbers and keep them somewhere easily accessible to you – on your fridge door for example.

Emergency services:	**999**
NHS Direct:	**0845 46 47**
Anti terrorist hotline:	**0800 789 321**
Cumbria Constabulary:	**Non Emergency Number - 101** (available 24 hours a day, 7 days a week).
Cumbria County Council:	**01228 606060**

Local District Council:

Doctor:

Work:

Schools:

Family contact 1:

Family contact 2:

Local Radio Station & Frequency: