Cumbria Joint Strategic Needs Assessment 2015-17

Overview and Introduction

Overview

The Health and Social Care Act 2012 amended the Local Government and Public Involvement in Health Act 2007 to introduce duties and powers for health and wellbeing boards (HWB) in relation to Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWSs).

JSNAs are assessments of the current and future health and social care needs of the local community. These are needs that could be met by the local authority, Clinical Commissioning groups (CCGs), or NHS England. These partner's plans for commissioning services will be expected to be informed by relevant JSNAs and JHWSs.

This is the overview and introduction for the new ongoing process for Cumbria's JSNA.

The JSNA will no longer be a one document product and will be supplemented and worked on continually over the next three years. The JSNA will be considered in topics where indepth, detailed analysis and recommendations can be identified. The table below details the topics and timing currently planned but will be continually reviewed by the HWB. These broad topic areas have been chosen to ensure wider factors are considered that impact on their communities' health and wellbeing, and local assets that can help to improve outcomes and reduce inequalities are reflected.

Table 1 – JSNA Topics and Timing (January 2015)

Year	Quarter	Topic
2015	1	Introduction & Overview
	2	Population
	3	Inequalities
	4	Mental Health and Wellbeing
2016	1	Older People
	2	Executive Summary
	3	Children and Families
	4	Economy

		Stay safe
2017	1	Learning and Employment
	2	Healthy Living/Lifestyles
	3	Environment & Sustainability
	4	Executive Summary
Core Dataset - Ongoing		

For the latest agreed topics and timings see
http://www.cumbriaobservatory.org.uk/health/JSNA/2015/homepage.asp

Each topic will have a summary written at the scheduled times which will allow an in depth examination of the topic and identify the key issues and recommendations for commissioners. The aim is to utilise information already available and to incorporate it into the JSNA as well as creating relevant new analysis. Therefore each topic will have a section within the observatory JSNA webpage that includes links to work produced that is considered relevant to the topic.

The JSNA is an ongoing process and it is envisaged the breakdown into topics will allow stakeholders to engage with the topics that are relevant and appropriate at an influential level. This approach also allows wider social, environmental and economic factors that impact on health and wellbeing to be fully considered such as access to green space, the impact of climate change, air quality, housing, community safety, transport, economic circumstances and employment.

This Overview & Introduction has been scheduled to help assign priorities for the Health and Wellbeing Strategy in the 2015 refresh. The executive summaries are intended to allow a review of current strategic headline information, assess trends in recommendations and gaps as well as incorporate timely information that cannot be included under a topic area.

The Health and Wellbeing Intelligence Group (HWIG) has been formed to produce the JSNA, the Locality Health and Wellbeing forums, Public Health Alliance and Health and Care Alliance will review the outputs before they are submitted to the to the HWB.

A template for the JSNA has been produced by HWIG to ensure all relevant aspects of a needs assessment are considered. This consistent layout and structure for topic summaries and executive summaries should provide easy navigation of documents. However the group has agreed that although all headings should be considered not all have to be incorporated in the output. The current template is the following:

Introduction

A review of headline information and intelligence has been undertaken to highlight some key issues and gaps at this time. This is not intended to be exhaustive but provide an overview to identify issues that commissioners should be aware of, identify elements that should be considered in future topics in more depth and provide an up to date evaluation of the current needs known to help identify priorities for the JHWS. As the JSNA is an ongoing process the key issues, gaps and recommendations will continually be developing.

Key issues & gaps

There are several key issues highlighted in this introduction:

- Cumbria has a diverse health picture, inequalities exist and are evident in Cumbria
- Due to rurality, accessibility in Cumbria is very limited in some areas
- Cumbria has an increasing proportion of older people
- Children and young people have a number of health indicators significantly worse than England

Gaps identified within the Introduction include:

- Military veterans - accurate numbers and locations in Cumbria are not known and consequently their particular needs
- Alcohol admissions – currently unable to detail the need in Under 18s alcohol

- Adult excess weight – there is a lack of understanding of why parts of Cumbria have particularly high prevalence.
- Mental health and wellbeing - currently there is no reliable wellbeing dataset for Cumbria at a lower geographical level

Recommendations for consideration for all commissioners

It is the responsibility of the Commissioner to ensure that any interventions or services are fully explored and do not increase inequalities.

Asset building and service development have to complement each other and should be considered by commissioners.

A health needs assessment for military veterans is recommended to be conducted.

What is the population overview?

The resident population of Cumbria was estimated to be 498,100 persons at mid-2013 from Office of National Statistics (ONS); an increase of + 6,700 persons (+1.4%) since mid-2003 (England & Wales +7.7%). All but one of Cumbria's districts followed the county-wide trend in experiencing an overall increase in population between mid-2003 and mid-2013; the exception being Barrow-in-Furness, where the population decreased by 4.3%, the second biggest decrease out of all local authority districts in England & Wales. The greatest proportional increase amongst Cumbria's districts was seen in Carlisle (+5%). The GP registered population tends to be slightly higher than the ONS figures and as of October 2014 513,922 patients were registered at GP practices in Cumbria.

17,734 Cumbrian residents reported that they were from Black and Minority Ethnic (BME) groups in their 2011 Census (3.5%). This is much lower than the average for England & Wales (19.5%). Across Cumbria's districts, the proportion of residents from BME groups ranged from 2.4% in Allerdale to 5% in Carlisle. Between Census Day 2001 and Census Day 2011, the number of residents from BME groups increased substantially both at national and county level, with Cumbria experiencing a greater increase than the England & Wales average; +85.2% compared to an increase of 68.1% for England & Wales. Numbers of residents from BME groups increased considerably across all of Cumbria's districts between 2001 and 2011, with the greatest increases seen in Carlisle (+143.4%) and Eden (+104.1%).

The data suggests that while Cumbria has a smaller proportion of residents from BME groups than the national average, as numbers of BME residents have increased more

rapidly in Cumbria than nationally in recent years, the ethnic profile of Cumbria is changing to become more representative of the rest of England & Wales.

When compared to England & Wales, Cumbria has an older age profile; with lower proportions of residents in the younger age groups (0-44 years) and higher proportions of residents in the older age groups (45-85+ years). The age profile of Cumbria's districts varies considerably. Barrow-in-Furness, Carlisle and Copeland have the greatest proportions of residents in each of the three youngest age groups. Inversely, Allerdale, Eden and South Lakeland have the greatest proportions of residents in each of the three oldest age groups.

Table 2 - Population overview data

	Cumbria	England	Allerdale	Barrow-in-Furness	Carlisle	Copeland	Eden	South Lakeland	Source
Population number	498,100	56,948,200 (England & Wales)	96,200	67,800	107,900	70,000	52,600	103,500	ONS, Mid-2013 Population Estimates
Proportion of persons 65+ years	22.2	17.4 (England & Wales)	22.3	20.3	19.6	20.5	23.5	26.2	ONS, Mid-2013 Estimates
Male Life expectancy at birth	79.0	79.4	78.9	76.9	78.9	77.7	80.6	80.8	2011-2013 PHOF
Female Life expectancy at birth	82.5	83.1	81.7	81.6	82.0	81.3	84.6	83.9	2011-2013 PHOF
Mortality rate per 100,000 from preventable causes (persons)	198.0	183.9	209.5	242.1	208.3	234.4	150.2	155.8	2011-2013 PHOF
% Bad or very bad health	6	5.6 (England & Wales)	6.3	8.4	6	6.8	4.5	4.5	Census 2011
% Day to day activities limited	20.3	17.9 (England & Wales)	20.8	24.6	19.2	21.3	18	18.8	Census 2011
% providing any unpaid care	11.3	10.3 (England & Wales)	11.2	11.9	10.5	11.3	11.3	11.8	Census 2011

Significantly worse than England

Similar to England

Significantly better than England

People across their life course have varying needs and health outcomes and both currently and historically the health of people is varied in Cumbria. Cumbria is ranked 77th out of 150 local authorities (1 = best, 150 = worse) when comparing number of premature deaths. Between 2010 to 2013 there were 5,250 premature deaths in the county (source: Longer Lives). Within the districts this ranking using premature deaths varies from 305th of 324 local authorities for Barrow in Furness to 63rd for South Lakeland.

Likewise life expectancy at birth portrays this variation in health and wellbeing and between some areas of Barrow and South Lakeland the difference in male life expectancy is 16 years and nearly 17 years for women. Utilising 2010-12 data the life expectancy gap between Cumbria and England for males and females is mainly attributable to external causes including injury, poisoning and suicide for males; and circulatory disease (including coronary heart disease) and stroke for females. However, when comparing the most deprived to the least deprived quintiles of Cumbria cancer is the largest contributor to the life expectancy gap (source: Segment Gap Tool, PHE).

Since 2000-02 life expectancy for males living in Cumbria has increased by three years; and in females an increase of 2 years suggesting an improvement in health across the county (source: PHOF).

Cardiovascular causes and cancer considered preventable in females and suicide in males is significantly worse in Cumbria than England (source: PHOF). In comparison to other local authorities premature death in Cumbria caused by breast cancer and injuries is worst (source: Longer Lives).

The most recent data for 2011-13 shows the mortality rate from causes considered preventable in Cumbria has shown a slight increase to 198 per 100,000 when historically the trend has been decreasing. Females in particular are showing an increase in the rate of preventable mortality.

In females 2104 years are potential years lost amenable to health care per 100,000 of the population; and in males 2198 years are potential years lost (source: CCG Outcomes Tool).

When compared to England & Wales, Cumbria has a similar proportion of residents with bad or very bad health self reported from 2011 Census (Cumbria: 6%, England & Wales: 5.6%). Of Cumbria's six districts, Barrow-in-Furness had the greatest proportion of residents with bad or very bad health (8.4%), while Eden and South Lakeland had the smallest proportions (both 4.5%). When compared to England & Wales, Cumbria has a slightly higher proportion of residents whose day-to-day activities are limited (Cumbria: 20.3%, England & Wales: 17.9%). Of Cumbria's six districts, Barrow-in-Furness had the greatest proportion of

residents whose day-to-day activities are limited (24.6%), while Eden had the smallest proportion (18%).

Nationally there is an increasing trend of numbers of people providing unpaid care. Furthermore when people provide increasing amounts of unpaid care they feel their health is worse. In Cumbria, in the 2011 census, 11.3% of respondents reported that they provide unpaid care compared to 10.3% nationally. Within the districts, Barrow-in-Furness has the highest proportion of residents providing unpaid care at 11.9% compared to 10.5% in Carlisle (the lowest).

With increasing life expectancy it is expected the number of people living with long term conditions in Cumbria is likely to increase. This is partly due to increased numbers of older people but also because some risk factors such as obesity and alcohol misuse are increasing. The GP patient survey 2012/13 suggests 72.6% of patients in Cumbria with long term conditions feel supported to manage their condition.

Who is at risk & why?

There is lots of health information available and it can be utilised to begin to understand the health picture in Cumbria. Highlights from the health information available are detailed in table 3 and is divided into health outcomes and health determinants.

Table 3 – Health data highlights for Cumbria

Area of health data	What in Cumbria is not good ☹	What in Cumbria is at risk of becoming worse ☹	What in Cumbria is getting better ☺
Health outcomes	• Life Expectancy & Gap • Female preventable cardiovascular and cancer mortality under 75 years • Killed or seriously Injured on Cumbria roads • Under 75 mortality in adults with serious mental health illness • Suicide rate • Attendances at A&E for a psychiatric disorder • Self harm hospital stays • Hospital admissions for substance misuse • All age and Under 18 alcohol related hospital stays • Tooth decay • Chlamydia detection • Injuries • Preventable sight loss • Sickness Absence	• Hip fractures • Under 75 years male mortality rate from respiratory causes	• Infant mortality • Completion of drug treatment
Determinants of health	• Older people Projections • Smoking At Time Of Delivery • Breastfeeding • Obese children • Excess weight • Adult inactivity • Happiness annual population survey • School readiness • PPV vaccination • Flu vaccination • Fuel poverty	• GCSE attainment	• Low birth weight • Percentage of people dying at home • Smoking prevalence • First time entry to youth justice system

More information in relation to each of the data highlights is detailed below:

Health Outcomes

Life Expectancy & Gap

In Cumbria life expectancy for males is 78.8 years; and for females it is 82.4 years. This is significantly shorter than England at 79.2 years and 83.0 years respectively. The difference in life expectancy between the most and least deprived areas in Cumbria is 9.6 years for males and 6.4 years for females.

Under 75 mortality in adults with serious mental health illness

There is extensive published evidence that people with severe mental illness, such as schizophrenia, die between 15 and 25 years earlier than the average for the general population. In Cumbria excess death in those under 75 with serious mental illness is significantly higher than England, at a rate of 430 compared to 337 in England.

Under 75 years female mortality

In Cumbria, the rate of premature (under 75 years) mortality from cardiovascular and cancer causes considered preventable in females is significantly higher than England. In Cumbria the rate of cardiovascular mortality considered preventable in females is 32 per 100,000 compared to 26.5 in England. In Cumbria the rate of cancer mortality in females considered preventable is 83.5 per 100,000 compared to 76.9 in England. These figures are contributing to the under 75 years preventable mortality rate being significantly worse in Cumbria than England which has been the case for the last 3 years.

Killed or seriously Injured on Cumbria roads

From 2010 to 2012 there was 226 persons killed or seriously injured on roads in Cumbria, a rate of 45.2, significantly worse than the England rate of 40.5.

Suicide rate

In 2011-13 the rate of suicide in Cumbria was 10.9 per 100,000 compared to 8.8 per 100,000 in England. Nationally the rate is higher in males reflected in Cumbria with a suicide rate of 17.9 per 100,000 compared to 13.8 in England.

Attendances at A&E for a psychiatric disorder

The proportion of patients with schizophrenia, bipolar affective disorder and other psychoses (as recorded on practice disease registers) is 0.89% which is higher than England at 0.84%. In Q1 in 2013/14, the rate of people in contact with mental health services was 2,198 per 100,000. Attendances at A&E for a psychiatric disorder are higher in Cumbria compared to

England at a rate of 355.1 per 100,000 compared to 243.5 in England, but lower than the North of England at 387.4 per 100,000. (Source: community mental health profile)

Self harm hospital stays

In 2012/13, the rate of hospital stays for self harm (which includes drug poisoning) were 255 per 100,000 compared to 188 per 100,000 in England.

Hospital admissions for substance misuse

In Cumbria the rate of hospital admissions for substance misuse for 15 to 24 year olds is significantly higher than England at 125.8 per 100,000 compared to 75.2 per 100,000 respectively (2010/11 to 2012/13). (source: Child Health Profile).

Alcohol admissions

In 2012/13, alcohol related admissions to hospital in Cumbria are significantly higher than England for both males and females. In Cumbria the rate of admissions is 706 per 100,000 compared to 637 per 100,000 in England. Under 18 admissions for alcohol harm for some of Cumbria's districts are amongst the highest in England. In 2010/11 to 2012/13 in Cumbria there were 76.4 hospital admissions due to alcohol specific conditions in children under 18 per 100,000 significantly higher than the rate for England at 42.7 per 100,000. (source: Child Health Profile)

Tooth decay

The most recent survey (2013) of 3 year olds indicates 4.5% of children in Cumbria have early childhood caries compared to 3.9% nationally. Hospital admissions of under 18 due to tooth extraction was lower in Cumbria at 0.4% than the rest of England at 0.48%. However, in the district of Barrow-in-Furness this increased to 0.91%.

Chlamydia detection

The chlamydia diagnosis rate amongst under 25 year olds is a measure of chlamydia control activities. The number of positives detected is highly dependent on the screening services offered to the population. It represents infections identified (reducing risk of sequelae in those patients and interrupting transmission onto others). Increasing diagnostic rates indicates increased control activity and are not a measure of morbidity. The target is to reach 2,300 detections per 100,000 of 15-24 year old population. This target is aimed to encourage high volume screening and diagnoses.

In 2013, Cumbria did not reach this target with a detection rate of 1,526 per 100,000 (a decrease from 2012). Within the districts only Carlisle had a detection rate above the national target of 2,300 per 100,000.

Injuries

In 0-14 year olds hospital admissions are higher for unintentional and deliberate injuries in Cumbria than they are nationally at a rate of 119 per 100,000. This is mainly due to a stabilisation locally but a decline nationally.

Preventable sight loss

The number of sight loss notifications in Cumbria is higher than national figures. This data cannot provide a precise figure because the figure is self reported so there may be under reporting, however, the data available suggests Cumbria has a higher rate of preventable sight loss compared to England. The component with the increasing trend in notifications is diabetic eye disease. Work should be ongoing to develop the understanding of where diabetes is more prolific, possibly due to obesity that the sight loss is increasing and could be prevented.

Sickness absence

Data from 2010-12 shows employees in Cumbria had significantly worse sickness compared to England both for percentage at least one day off week previous 2.8% compared to 2.5% and percentage of working days lost 2.1 compared to 1.6 in the previous week.

Hip fractures

Cumbria is showing a slightly increasing trend in hip fractures in those over 65 years with Carlisle, Copeland and South Lakeland showing an increase in 2012/13. Copeland district is also showing an increase in the rate per 100,000 of those over 65 suffering injuries from falls.

Male Under 75 mortality rate from respiratory disease

In Cumbria, the rate of premature (under 75 years) mortality from respiratory causes considered preventable is showing an increasing trend since 2009-11. In 2011-13 the rate was 19.8 per 100,000 compared to andr ate in England of 20.4 per 100,000. The North West has a higher rate of 25.7 per 100,000.

Late stage HIV presentation

51.5% of adults presenting with HIV do so at a late stage in Cumbria compared to 48.3% in England

Some health outcomes are showing an improving picture in Cumbria, these are as follows:

Infant Mortality

Since 2008-10 the infant mortality rate in Cumbria has decreased to a rate better than the national figure. Crude rate of 3 per 1,000 compared to 4.1 in England.

Successful completion of drug treatment

In 2013 there was an improvement in the number of people completing drug treatment in Cumbria for both those dependent on opiates (11.5%) and non opiates (39%). This compares to 7.8% for opiate treatment nationally and 37.7% for non opiate treatment nationally.

Determinants of health

Projections of older people

By 2037 the proportion of residents aged 65+ is projected to increase to 32.9% across Cumbria; this is the third greatest projected proportion of all counties in England and much higher than the projected national proportion (24%). All of Cumbria's districts are projected to have greater proportions of residents aged 65+ than the national average by 2037. South Lakeland and Eden are projected to have the greatest proportions of residents aged 65+ (37.2% and 36.2% respectively by 2037).

Smoking at time of delivery

In 2013/14, 13.8% of mothers were smoking at time of delivery, above the national average of 12.0% but below the North West region figure of 15.3%.

Breastfeeding

Nationally 73.9% of maternities have breastfeeding initiated, in Cumbria this falls to 66.4%.

Obese children

In 4-5 year olds 25.1% of children have excess weight, and in 10 to 11 years old this increases to 33.4%. This proportion of overweight and obese 4-5 year olds in 2013/14 is significantly higher than the national average of 22.5%.

Excess weight

68.3% of adults in Cumbria are overweight compared to 66% in the North West and 63.8% in England. The districts show a varying percentage of excess weight adults from 65.8% in South Lakeland to 75.9% in Copeland. This may cause other illnesses such as diabetes to be higher if not now in the future if the trend for excess weight continues.

Adult inactivity

In 2013, the proportion of inactive adults in Cumbria was 31.3% compared to 28.9% in England – the trend is increasing at a higher rate than England.

Happiness annual national population survey

Life satisfaction – 4% of the 904 people questioned had low life satisfaction in Cumbria compared to 5.6% for England; 80% of respondents reported they had high or very high life satisfcation. Cumbria's response mean was 7.72 (presenting high satisfaction), with mean responses ranging from 7.38 to 7.83 out of 10 across the districts. Barrow in Furness had the lowest mean response although it is noted the sample size was low for the district at 96.

School readiness

The proportion of children obtaining a good level of development at the end of reception is 49.7%, below the national and NW figure of 51.7% and 50.4% respectively.

Pneumococcal (PPV) vaccination

In 2012/13 the coverage of the PPV vaccine in those aged over 65 years was decreasing (down from 70.4% to 66.4%) suggesting less of our population in Cumbria is covered.

Flu vaccination

In 2012/13 there was a 60.2% uptake for flu vaccination for at risk persons aged 16-65 years. The target is 75% and currently coverage is 51.3% nationally.

Fuel poverty

In 2012, 11.6% of households were considered to be living in fuel poverty (using the Low Income High Cost methodology) compared to 10.4% nationally.

GCSE attainment

In 2013/14, 56.8% of children in Cumbria obtained key stage 4 (GCSE) 5+ A*-C including English and Maths compared to a national average which was also 56.8% (state funded maintained schools). Historically Cumbria has had a lower percentage than England for GCSE attainment and due to significant changes to the GCSE methodology, the headline measure of 5+ A*-C (including English and maths) is not really comparable to previous years so there is no trend to consider at his time.

Several health determinants, detailed below, are showing an improvement in Cumbria:

Low birth weight

After a rise in 2009 the rate of low birth weight babies has returned to a rate better than England in 2011 and 2012. With a proportion of 2.2% in Cumbria in 2012 with a low birth weight compared to 2.8% in England.

Place of death

Given the option most people would choose to die at home surrounded by those they love. In 2010-12, 23.5% of Cumbrian residents died at home, this is significantly higher than the England figure of 21.5%. (source: End of Life Care, CCG profile).

Smoking prevalence

In 2013, smoking prevalence In Cumbria has decreased to 18.1% of the population compared to 18.4% in England. These figures vary considerably across the county with a prevalence of 23.1% in Barrow compared to 14.1% in South Lakeland. All districts that had a prevalence higher than England historically have a decreasing trend.

First time entry to youth justice system

Nationally the rate of first time entrants is decreasing. Since 2011 there has been a 69% decrease. The rate in Cumbria continues to be significantly better than England, 322 and 441 per 100,000 respectively. Mapping of the areas across the county should continually be refreshed due to the changing picture. Those entering the system more often have more unmet health needs than other children.

What is the level of need and gaps?

Within each of the topic summaries there will have to be an assessment of need which will be more detailed and specific.

Health and wellbeing is often clearly linked to deprivation and this is often displayed in analysis within Cumbria. Therefore the indices of multiple deprivation (IMD) are important for understanding the population. Cumbria has 29 communities that rank within the 10% most deprived of areas in England, with 8.3% of the county's population living in 29 these communities. Furthermore, eight of Cumbria's communities are classified as being within the 3% most deprived nationally, with 2.3% of the county's residents living within these eight communities (which are located in parts of Moss Bay (Allerdale), Barrow Island (Barrow), Central (Barrow), Hindpool (Barrow), Ormsgill (Barrow) and Sandwith (Copeland) wards).

14.1% of children (0-19 years) living in Cumbria are living in poverty, below national levels of 18.6% for England. Despite this, there are pockets of severe poverty spread across the county - 48.4% of children living in the ward of Central in Barrow are living in poverty. 11.6% of households in Cumbria are in fuel poverty, above national levels of 10.4% for England. This increases to 48.2% in some communities (Barrow Island) across the district.

In 2015 the Indices of Multiple Deprivation will be updated, this updated dataset will be essential for commissioners to refer to when considering services and other work. A briefing relating to the IMD data in Cumbria will be published by the Cumbria Intelligence Observatory when available.

Other measures of social and economic disadvantage, such as Department of Work and Pensions (DWP) benefits claimants; and household with income less than £10,000 per year, show strong correlations with deprivation scores; with the highest levels of DWP benefits claimants and low household income found in the most deprived areas.

However, it is important to note that although large numbers of people who are socially and economically disadvantaged live in the most deprived areas, there are households and neighbourhoods within more affluent areas that also experience social and economic disadvantage.

Table 4 – Identifying need data

	Cumbria	England	Allerdale	Barrow-in-Furness	Carlisle	Copeland	Eden	South Lakeland	Source
Indices of Multiple Deprivation (IMD) rank percentile, 1 is most deprived	85th (out of 149)		34	10	33	24	65	74	2010 DCLG
% Children in Poverty (0-19 years)	14.1	18.6	15.4	20.4	15.3	16.6	7.9	7.6	2012 HMRC
Minimum average travel times to key services by walking/public transport (mins)	16	12	13	11	13	15	28	18	2014 DfT
Minimum average travel times to major road junction (mins)	31	25	43	44	10	61	18	18	2014 DfT
% households with no car/van	21.4	25.6 (England & Wales)	20.8	29.9	24.7	23.4	13.9	15.3	Census 2011
Proportion of person 65+ in 2037	32.9	24.0	33.3	29.4	30.2	31.8	36.2	37.2	2012-Based SNPPs, Office for National Statistics

In Cumbria another key issue when considering need is accessibility. The Department for Transport (DfT) publish accessibility statistics considering travel times to eight key services (employment centres, primary schools, secondary schools, further education institutions, GPs, hospitals, food stores and town centres) by three modes of transport (public transport/walking, cycling and car).

The average minimum travel time to reach key local services across Cumbria was 16 minutes by public transport / walking, 14 minutes by cycle and 7 minutes by car; these times were all longer than the national averages of 12, 9 and 6 minutes respectively.

There was much variation between Cumbria's districts in the accessibility of key services. Of the county's districts, Eden had the longest average minimum travel time to reach key local services; 28 minutes by public transport / walking, 31 minutes by cycle and 10 minutes by car (the 2nd longest times for all three modes out of all local authorities nationally, Isles of Scilly was longest). In contrast, Barrow-in-Furness had the shortest average minimum travel times in Cumbria to reach key local services (11 minutes by public transport / walking, 7 minutes by cycle and 5 minutes by car).

Due to the accessibility issues there is an increased reliance on cars in rural areas like Cumbria. Consequently the rural cost of living is higher than that in urban areas. The majority of increased costs coming from home maintenance, personal transport, fuel and energy (NFU mutual). In Cumbria 21.4% of households do not have a car or van available compared to 25.6% nationally. As anticipated urbans areas tend to have higher proportions of households without a car or van compared to rural areas.

As well as connectivity Cumbria also has to consider connectivity and DfT also publish average travel time by car to main road junctions which like accessibility is longer at 31 mins in cumbria than the national figure of 25 mins. The figure varies between the districts with an average travel time of 61 mins in Copeland and 10 mins for Carlisle.

Because Cumbria's current age profile is older than the national average and the county is projected to experience a decrease in numbers of residents aged under 65 in addition to significant increases in residents aged over 65, the county's projected age profile is much older than the projected national age profile. By 2037, the proportion of residents aged 65+ is projected to increase to 32.9% across Cumbria; this is the third greatest projected proportion of all counties in England and much higher than the projected national proportion (24%). All of Cumbria's districts are projected to have greater proportions of residents aged 65+ than the national average by 2037. South Lakeland and Eden are projected to have the greatest proportions of residents aged 65+ (37.2% and 36.2% respectively by 2037). The

ageing of our population in Cumbria should be considered when commissioning not only for anticipated increased demand on adult health and social care services but also for any opportunities.

Needs in Cumbria are a challenge to meet due to the number of older people, the distance between deprived locations and the difficulty in accessing services in some areas.

The data has also displayed how inequalities are evident in Cumbria and commissioners need to consider the work they are doing will not increase inequalities. This reinforces why a inequalities topic is necessary and detail will be described further in the topic summary.

Due to the evidence available relating to children and young people a number of health indicators relate to this risk group, with so many of these indicators both health and wider determinant identified as significantly worse in Cumbria than in England the needs of this groups should be prioritised.

Within each of the topic summaries specific needs relevant to that area will be identified.

Whilst compiling this introduction and overview several gaps were identified and are discussed here:

Military veterans

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 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.

From a report in 2012, there were estimated to be around 43,121 retired armed services personnel in Cumbria. However accurate numbers and locations are not known. It is recognised that the health of this group of people may not be comparable to the rest of the county residents due to the increased fitness, increased risk of death and a possible higher number over 65 years due to national service previously. Therefore it is recommended a health needs assessment is conducted for this group.

Alcohol admissions

Cumbria as detailed earlier has high proportions of alcohol related hospital admissions particularly in the under 18 age group. There is work ongoing to understand the issue but there is currently a gap in being able to detail the need.

Adult excess weight

Cumbria has high levels of adults with excess weight that are significantly worse than England. Copeland in particular has high levels and current data suggests the district has the highest levels of adult excess weight in the country. Despite this data a lot is unknown about why Cumbria (particularly Copeland) had such high levels. Levels of childhood obesity and excess weight are also high but what is making Cumbria different is not evident.

Mental health

National surveys to ensure continuation are often utilising smaller numbers of respondents which can result in a lack of accurate data particularly at lower geographical levels which as detailed throughout this summary is required for full understanding of health and wellbeing in communities. Currently there is not a reliable wellbeing dataset for Cumbria at a lower geographical level.

Current Services and Assets including projections

There are some well recognised stakeholders of the health and wellbeing system in Cumbria

- North Cumbria University Hospital Trust
- University Hospitals of Morecambe Bay
- Cumbria Partnership NHS Foundation Trust
- Cumbria Clinical Commissioning group
- Cumbria County Council
- District Councils (Allerdale, Barrow-in-Furness, Carlisle, Copeland, Eden & South Lakeland)
- Third Sector
- Cumbria Constabulary/Office of Police and Crime Commissioner

Therefore the health and wellbeing system has services and assets that are far reaching across Cumbria and span all health and wellbeing issues. In future topics services and assets should not be limited to considering the well recognised stakeholders.

In relation to health and current services it is well recognised that in Cumbria there are areas under significant pressure.

Cumbria has been described as having a challenged health economy and the current challenges have been clearly described in the Interim Cumbria Local Health Economy Strategic Plan. These include the significant regulatory intervention from the Care Quality Commission (CQC) regarding the quality of a wide range of services. At the time of writing both North Cumbria University Hospitals NHS Trust and University Hospitals of Morecambe Bay NHS Foundation Trust are in special measures, the highest level of escalation in the NHS.

There are financial challenges in obtaining the best value from resources combined with efficiency challenges. Additionally, communities are worried that valued local services will be lost and that the NHS system will make bad choices in order to balance the books.

Across Cumbria it continues to be very difficult to attract the right clinical staff, particularly in some specialist areas.

Due to the challenges there is lots of work is ongoing to improve services in Cumbria and one of the most significant pieces of work is in the approach to services by the integration of health and social care working in Cumbria to improve care and reduce hospital admissions.

Asset working is continuing across Cumbria with the implementation of the ABCD (Asset Based Community Development) approach. It is local and continually building community resilience therefore difficult to describe at a county strategic overview.

This introduction does not attempt to summarise all current work but individual health and service needs assessments will explore the relevant services and assets in each topic.

Ultimately the JSNA and its components will provide data and intelligence to help focus where and what asset building/understanding or community resilience could be most effective. Within topics (where appropriate) assets will be considered as well as community need in order to maintain a balanced approach. The balance is essential with increased pressure on budgets and the partnership between community resilience and service development must be a complement.

Strategic direction

The NHS Five Year Forward View was published on 23 October 2014 and sets out a vision for the future of the NHS. The Five Year Forward View starts the move towards a different NHS, recognising the challenges and outlining potential solutions to the big questions facing health and care services in England. There are various elements covered in the vision but it is clear prevention is understood to be vital in improving the health and social care system. There is an emphasis on tackling obesity, smoking, alcohol and other major health risks.

With the introduction of the care act reforms in 2015 carers will be more supported and person centred care is the focus contributing to improved health and wellbeing of the community. The integration of health and social care continues in Cumbria via the Together for a Healthier Future in north Cumbria and Better Care Together programme in South Cumbria.

A focus on child safeguarding will remain a key cross cutting priority for all public agencies. In particular the Cumbria Local Safeguarding Board has highlighted the importance of tackling Child Sexual Exploitation. This will include a broad programme of activity from raising organisational awareness of the issue, to ensuring that victims are receiving prompt and effective support, to disrupting the perpetrators.

Equality Impact Assessment

The JSNA must consider how needs may be harder to meet for those in disadvantaged areas or vulnerable groups who experience inequalities, such as people who find it difficult to access services; and those with complex and multiple needs such as looked-after and adopted children, children and young people with special educational needs or disabilities, troubled families, offenders and ex-offenders, victims of violence, carers including young carers, homeless people, Gypsies and Travellers, people with learning disabilities or autism who also have mental health conditions or behaviours viewed as challenging. Each future topic should consider these groups when assessing information for needs.

Geographical differences in need

As previously highlighted, Cumbria's overall performance in a range of health and wellbeing indicators can disguise local issues or strengths. Recognition should be given that services may have to adapt to different places and small areas/isolated areas may have to be considered and where possible lower geographical data should be considered.

There is a brief summary of health outcomes for each district below and the PHE produced health profiles can found here:
http://www.cumbriaobservatory.org.uk/health/JSNA/previous/Districts.asp

It is intended following the release of updated IMD data in the summer 2015 health intelligence profiles for each district will be produced to supplement the PHE profile reporting relevant local data tailored for each district.

Allerdale

Life expectancy is lower than the England average for males and females; males life expectancy is 78.2 years (79.2 years for England) and female life expectancy is 81.9 years (83.0 years for England). In Allerdale the mortality rate from causes considered preventable is higher than England with a rate 206.2 per 100,000 population in Allerdale compared to 187.8 in England. Persons under 75 years in Allerdale have a higher rate (63.3 per 100,000) of preventable cardiovascular mortality compared to England (53.5 per 100,000).

Hospitals stays for self harm for persons in Allerdale are at a higher rate than England at 259.4 per 100,000 compared to 207.9 respectively.

From 2007/08 to 2009/10 there were 28 hospital stays for under 18s due to alcohol specific conditions. This equates to a rate of 144.9 per 100,000 of the population, significantly higher than the rate for England at 61.8.

The proportion of overweight 10-11 year olds in Allerdale is 39.9 %, higher than England at 33.3%. Proportions of 4-5 year olds; and adults overweight in Allerdale is currently similar to England figures.

Barrow in Furness

The health of people in Barrow in Furness district is generally worse than the rest of England. Life expectancy is shorter in Barrow in Furness by 2.1 years for males and 1.6 years for females compared to England (79.2 years and 83.0 years respectively).

The rate of preventable mortality is higher in Barrow in Furness district (243.6 per 100,000) than in England (187.8 per 100,000). The rates of several preventable causes in persons under 75 years are significantly higher in Barrow in Furness compared to England: preventable cardiovascular causes (105.1 per 100,000); preventable cancer causes (102.0 per 100,000) and preventable liver disease causes (25.2 per 100,000). The most important cause of preventable ill health nationally is smoking and in Barrow in Furness the prevalence is significantly higher than England at 26.1% compared to 19.5%.

Excess weight in children is higher in Barrow in Furness than England for both 4-5 year olds and 10-11 year olds. The proportion of 4-5 year olds overweight in Barrow in Furness is 25.5% compared to 22.2% in England. In 10-11 year olds the proportion overweight in the district is 37.1% compared to 33.3% in England.

The mean number of decayed, missing or filled teeth in 5 year olds is higher in Barrow (1.45) than England (0.94).

Hospital admissions in 0-14 year olds (166.1 per 10,000) and 15-24 year olds (211.5 per 10,000) for unintentional and deliberate injuries is higher in Barrow in Furness than England (103.8 and 130.7 per 10,000 respectively).

Carlisle

Within Carlisle district there are health issues highlighted from mortality data. The mortality rate with preventable causes is higher in Carlisle (72.9 per 100,000) than England (58.7 per 100,000). This is particularly evident in the rate of preventable respiratory mortality for those under 75 years old. Smoking prevalence of the adult population is higher in Carlisle district than in England at 24.7% compared to 19.5% nationally. Many complex factors can contribute to reduce a person's life expectancy and for residents in Carlisle district their life expectancy is less than the England average (78.5 years in males compared to 79.2 years in England; and 82.0 years for females compared to 83.0 years in England). There are also more adults overweight in Carlisle than the England average with 68.4% persons over 16 overweight in Carlisle compared to 63.8% nationally. Sickness absence is higher in Carlisle with 4.1 % of employees reporting taking time off in the previous week compared to an England value of 2.2%, this relates to a percentage of working days lost to sickness as 2.9% working days in Carlisle compared to 1.5% in England. Pupil absence is significantly higher at 5.88% in Carlisle compared to the national figure 5.26% in England.

There are other health indicators worth highlighting in children and young people in the Carlisle district. There is significant tooth decay in 5 year old children with the mean number of decayed/missing/filled teeth per child of 1.26 compared to 0.94 in England. The rate of under 18 year old pregnancy is also higher in Carlisle (39.8 per 1,000 of 15-17 year olds compared to 30.7 in England). Measured weight in children is not displaying an increasing trend or a significantly high percentage of overweight children in Reception and Year 6, however in Carlisle 34.6% of 10-11 year olds are measured as overweight.

Copeland

In Copeland males and females are living shorter lives than England with life expectancy 77.6 years for males and 81.4 years for females compared to 79.2 years and 83.0 years in England respectively.

Preventable mortality is higher in Copeland compared to England. Persons under 75 years old dying of preventable cardiovascular causes is higher in Copeland (64.7 per 100,000) than England (53.5 per 100,000). The rate of suicide of males in Copeland is higher than England with a rate in Copeland of 25.0 per 100,000 where as in England the rate is 13.3 per 100,000.

Prevalence of excess weight is a major determinant of premature mortality as well as avoidable ill health and is evident in Copeland in both children and adults. 27.6% of 4-5 years are overweight compared to England 22.2%. This increases to 41.3% in 10-11 years olds compared to 33.3% in England. The proportion of overweight adults in Copeland is 75.9% compared to 63.8% in England.

As well as excess weight, there is a higher prevalence of smoking (the most important cause of ill health and premature mortality in the UK) in Copeland at 25.8% of the adult population compared to 19.5% in England.

Tooth decay is higher in 5 year olds in Copeland with the mean number of decayed, missing or filled teeth is 0.33 higher than England. Hospital admissions for unintentional or deliberate injuries is higher than the national average for the district's 0-14 year olds and 15-24 year olds; 139.9 and 175.1 per 10,000 respectively compared to England 103.8 and 130.7 per 10,000.

Eden

The health of people in Eden is generally better than the rest of England. Life expectancy of males and females in Eden is significantly better than England with average life expectancy in Eden at 80.3 years for males and 84.1 years for females. In Eden 68.8% of the adult population are overweight, higher than the England average (63.8%). Obesity is recognised as a major determinant of premature mortality and avoidable ill health. Although the current indicators of premature mortality and ill health are generally comparable or significantly better than England this excess weight data highlights a risk factor for the future. In Eden there is a diagnosis rate for chlamydia of 1,104 per 100, 000 15-24 year olds this is below the England value 1,979. The control of chlamydia is improved by diagnosing more infections, provided treatment and partner notification standards are met.

On Eden district roads those killed or seriously injured in road traffic accidents has decreased in 2010-2012 to 90.8 per 100,000 population but this rate is still significantly higher than the England rate of 40.5.

South Lakeland

The health of residents in South Lakeland is generally better than the rest of England. The life expectancy of males in South Lakeland is longer than England at 80.9 years compared to 79.2 years. Life expectancy for females in South Lakeland is similar to England (83.4 years compared to 83.0 years).

The prevalence of smoking in adults is less in South Lakeland at 12.7% compared to 19.5% in England.

The rate of hospital admissions for 15-24 year olds is significantly higher in South Lakeland (160.8 per 10,000) compared to England (130.7 per 10,000). Amongst 15-24 year olds in South Lakeland there is a diagnosis rate of chlamydia of 1,378 per 100, 000, this is below the England rate of 1,979. The control of chlamydia is improved by diagnosing more infections, provided treatment and partner notification standards are met.

As well as district information some ward data is available and can be found at http://www.localhealth.org.uk/#v=map9;l=en

Key Contacts

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Links to data sources

PHOF http://www.phoutcomes.info/

Local health http://www.localhealth.org.uk/#v=map9;l=en

CCG outcomes tool http://ccgtools.england.nhs.uk/ccgoutcomes/flash/atlas.html

PHE general health profiles
http://www.apho.org.uk/default.aspx?QN=P_HEALTH_PROFILES

Community mental health profiles http://fingertips.phe.org.uk/profile-group/mental-health/profile/cmhp

Child health profiles
http://atlas.chimat.org.uk/IAS/dataviews/report/fullpage?viewId=439&reportId=489&geoId=4&geoReportId=4432

Segment tool
http://www.lho.org.uk/LHO_Topics/Analytic_Tools/Segment/TheSegmentTool.aspx

References

Interim Cumbria Local Health Economy Strategic Plan 2014-2019
http://www.cumbriaccg.nhs.uk/about-us/key-policies/interim-cumbria-local-health-economy-strategic-plan-2014-19.pdf

JSNA guidance

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215261/dh_131733.pdf

Five year forward view

http://www.england.nhs.uk/ourwork/futurenhs/

The care act

http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted