This document is a summary of the health and social care needs in Cumbria. It does not describe all of Cumbria's needs and is a single snap shot at this point in time.

Assessing needs is an on-going process.

More detailed information is available on our web site at www.cumbriaobservatory.org.uk/health/JSNA/2012.asp

Updates, new sections and individual needs assessments are continually being added.
As an additional factor, many Cumbrian communities are located in some of the most rural parts of England and we recognise the added challenge of delivering sustainable services in remote rural areas. We aim to address this challenge by listening, working together and learning from best practice.

A sustainable health and social care system for the future can only be achieved if professionals and communities work together to improve health, there is a greater emphasis on making sure our children get the best start in life and a greater emphasis on helping people to stay healthier for longer, being equipped with the skills to make the right health choices and supported to take more ownership of their own care where appropriate.

I believe that this refresh of the JSNA will ensure that all organisations that have a part to play in the overall health of our communities will have a common set of goals that we can work to, collaborate on, and deliver together.

The social, economic and environmental conditions across Cumbria are powerful determinants of future health. If we are to reduce health inequalities we need to build capacity and create strong local partnerships that give more people better life chances.

The key to capacity building, particularly at a time of austerity and scarce resources, is the leverage provided by synergy and effective joint working. The challenges and devastating incidents that we have faced as a county over recent years have demonstrated Cumbria’s enormous community spirit and resilience in times of adversity. The community and professional response to events including the floods in 2009, the Keswick School bus crash in 2010, and the devastating shooting incident in Whitehaven also in 2010, have reinforced the value of community and the importance of communities and services coming together to help and support each other.

The JSNA process is ongoing and one of continual improvement. Instead of describing communities in terms of need and deprivation, it will, over time, develop to include an enhanced focus on the human and physical assets and social capital of our communities. We have begun to do this by including ‘asset’ case studies in the 2012-2015 JSNA. We will build on this community cohesion to ensure that we work together to face the challenges of the future, improve health outcomes and give all people in Cumbria the opportunity for a long and healthy life.

Our long term vision and strategic direction is for a place where people have bright prospects and abundant opportunities, where shared decision making will become the norm: no decision about me, without me.

This JSNA is a crucial evidence base to underpin this work and develop better outcomes for everyone in Cumbria.
### Cumbria in numbers

<table>
<thead>
<tr>
<th>National Comparison</th>
<th>Trend</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cumbria is England’s second largest county with a population of 494,400 people. The county represents 48% of the land mass in the North West.</td>
<td>N/Av</td>
<td>Office for National Statistics, 2010 Mid Year Estimates</td>
</tr>
<tr>
<td>There are 73 people per km². Population density is highest in Barrow at 906 people per km² and lowest in Eden at 24 people per km².</td>
<td>N/Av</td>
<td>Office for National Statistics, 2010 Mid Year Estimates</td>
</tr>
<tr>
<td>51% of Cumbria’s total population live in rural areas. This compares to 19% of the population in England and Wales.</td>
<td>N/Av</td>
<td>Office for National Statistics, 2010 Mid Year Estimates</td>
</tr>
<tr>
<td>Since 2001, the population of Cumbria has risen by 1.3% compared to a 5.3% rise nationally.</td>
<td>N/Av</td>
<td>Office for National Statistics, 2010 Mid Year Estimates</td>
</tr>
<tr>
<td>There were 5,068 live births and 5,431 deaths in Cumbria during 2010.</td>
<td>N/Av</td>
<td>Office for National Statistics, Vital Statistics, 2010</td>
</tr>
<tr>
<td>31% of working age residents are qualified to NVQ level 4 or higher.</td>
<td>N/Av</td>
<td>Annual Population Survey, January 2010- December 2010</td>
</tr>
<tr>
<td>49% of people with a disability in Cumbria are employed. This varies from 26% in Copeland to 70% in Allerdale.</td>
<td>N/Av</td>
<td>Annual Population Survey, July 2010- June 2011</td>
</tr>
<tr>
<td>31% of people feel that they can influence decisions affecting their area.</td>
<td>N/Av</td>
<td>Cumbria Place Survey Tracker, 2009</td>
</tr>
<tr>
<td>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.</td>
<td>N/Av</td>
<td>Cumbria Place Survey Tracker, 2009</td>
</tr>
<tr>
<td>The average household income is £26,004, nearly £3000 less than the national average.</td>
<td>N/Av</td>
<td>CACI Paycheck 2011</td>
</tr>
<tr>
<td>The mean average house price is £167,455. The average house in South Lakeland costs £126,353 more than in Barrow.</td>
<td>N/Av</td>
<td>CACI Street Value 2011</td>
</tr>
<tr>
<td>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.</td>
<td>N/Av</td>
<td>Cumbria Intelligence Observatory, Labour Market Briefing, March 2012</td>
</tr>
<tr>
<td>13.8% of households in Cumbria have an annual income of less than £10,000.</td>
<td>N/Av</td>
<td>CACI Paycheck 2011</td>
</tr>
<tr>
<td>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.</td>
<td>N/Av</td>
<td>Indices of Multiple Deprivation, 2010</td>
</tr>
<tr>
<td>4.9% of Cumbria’s population are from black, minority and ethnic groups compared to 16.7% in England and Wales.</td>
<td>N/Av</td>
<td>Office for National Statistics, 2009</td>
</tr>
<tr>
<td>258 people were killed or seriously injured on our roads during 2010 and 2011.</td>
<td>N/Av</td>
<td>Cumbria Constabulary</td>
</tr>
</tbody>
</table>
Executive Summary

Everyone faces the challenges of providing high quality, integrated and accessible services that reflect the needs of the population, offer choice and improve health and wellbeing. These challenges are faced everywhere, however the scale and nature of the challenge in Cumbria is compounded by our geography, an ageing population and the expected pressure on future resources. Meeting these challenges requires radical change.

The story of health and wellbeing in Cumbria is mixed and varies significantly by district.

Health inequalities and the associated risk factors are extremely well understood. We have a wealth of data and intelligence and a robust approach to ensuring this is kept up to date. Improvement work is being carried out at a faster rate in areas of deprivation than in other areas, yet despite this, and despite the overall levels of health improving, the gap between best and worst is widening.

Health outcomes are poorest in Barrow-in-Furness and Copeland. Barrow-in-Furness is the third most deprived district in England in terms of health. In contrast both Eden and South Lakeland have high levels of health and wellbeing.

Cumbria’s overall performance in a range of health and wellbeing indicators disguises significant inequalities in health outcomes. There is a 19.5 year gap between the wards with the highest and lowest life expectancies in the county, with life expectancy in some areas 8.4 years below the national average.

The main causes of premature mortality in Cumbria are cancer (particularly lung cancer) and circulatory disease.

Cumbria has a higher than national average proportion of older residents and the population is ageing faster than national rates. The ageing nature of our population presents significant future health challenges for the county, with demand on adult health and social care services projected to rise significantly in the future.

With the exception of Eden and South Lakeland, substance misuse, especially alcohol, is a significant issue in Cumbria. The problem is most pronounced in Barrow-in-Furness which has some of the highest rates of alcohol related harm in England and levels of serious drug misuse significantly above county and national averages.

The mortality rate from suicide and injuries undetermined in Cumbria is higher than the national average, with particularly high levels in Allerdale and Carlisle. Other indicators of mental health show significant issues in Barrow-in-Furness with the rate of admissions for deliberate self harm in the district over three times that of Eden.

There are also significant issues relating to the health of children and young people in some areas of the county. Rates of teenage pregnancy in Carlisle are significantly above the national average while Allerdale has the fourth highest rate in England of under 18s admitted into hospital for alcohol specific conditions.

A shift in health and social care is needed, where knowledge and expertise within communities becomes a leading principle and a health literate population will manage many more common conditions for itself. A great deal of the burden of preventable ill health must be prevented, with 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 must become expert patients, managing their condition for themselves, but with professional support.

A community wide debate on end of life care is also needed to ensure a big shift towards quality home death.
Key considerations for commissioners:

Challenge 1 - Inequalities

- **Build a health and social care system based on good intelligence.** The JSNA is an ongoing process. A robust intelligence service, joined up across all public sector organisations and accessible to all, can provide an evidence based system for identifying improvements, establishing options and targeting services that lead to better health and social care systems.

- **Use all available resources.** All public and private organisations must work together to build capacity and improve health and wellbeing. In particular, given that smoking is a major factor in premature mortality and health inequalities, all public, private and 3rd sector organisations should play a part in helping people to stop smoking.

- **Involve our communities and the voluntary sector.** There must be a strong emphasis on public health initiatives, public engagement, self management and a continuation of the commitment to orientate services closer to home to enable our citizens and communities to self manage and be in control of their own health outcomes. There is also a need for more systematic engagement with the voluntary sector which can be a real engine for innovation.

- **Recognise inequalities in all work programmes.** By explicitly recognising the impact that factors such as employment and skills, transport, recruitment, procurement, community engagement, facilities management, economic development and regeneration have on health – the public sector can begin to address inequalities and improve health and wellbeing.

Challenge 2 – Children and Young People

- **Ensure children get the best start in life.** Experience, life chances and habits developed in the early years shape future health outcomes later in life. Continued support needs to be given to maternal health and maternal behaviours, especially smoking and nutrition before, during and after pregnancy, and nutrition in early years, including breastfeeding.

- **Prioritise lifestyle improvement, particularly around obesity.** Lifestyle and behaviours such as smoking, alcohol and substance misuse in children all have a significant influence on later health outcomes and life chances. In particular, given that obesity is a risk factor for so many diseases, action to reduce childhood obesity will prevent significant ill health in the Cumbrian population in the future, as well as avoiding the financial costs associated with treating conditions linked to obesity.

- **Integrated services and partnership working.** Given the impact of the social and economic determinants on children’s health, partnership working between the NHS, local authority, voluntary sector and other partners to tackle these determinants and improve the health of children in Cumbria is necessary. The effective integration of services for safeguarding children and young people and promoting the mental health and wellbeing of children looked after is of significant importance.

- **Promote mental and emotional wellbeing.** Improving the mental health and wellbeing of young people is crucial to their long term life prospects. The provision of organised activities during the school holidays that provide a positive purpose and engage young people is essential.
Challenge 3 – Mental Health and Wellbeing

- **Good mental health is more than just the absence of mental illness.** Screening programmes, such as the NHS Health Checks programme, offer an ideal opportunity to emphasise wellbeing and the need for self management. All public sector staff should be encouraged to make “Every Contact Count” by providing information about the ‘Five Ways to Wellbeing’ – connect, be active, take notice, keep learning and give – and help people build them into their everyday lives.

- **Mental health and physical health problems often coexist.** Health and wellbeing would be improved by increasing access to psychological therapies for people with physical health problems; improving pathways for people with a ‘dual diagnosis’ of mental illness and drug and alcohol problems; and ensuring that people with learning disabilities have access to appropriate information related to their health.

- **Improve services and contain mental health related costs.** The impact of investment in mental health prevention and continued work to develop mental health services within Cumbria to avoid costly out of county placements and to reduce hospital admissions for mental health should improve outcomes and show a cost benefit.

Challenge 4 – Ageing Population

- **Increasing numbers of people will live to a greater age with a number of long term conditions.** Historically, investment in long term conditions has been on treatment and prevention of further deterioration, future investment should be focused on preventing or delaying the onset of long term conditions. People will need to be supported to self-manage their conditions through better patient education and enhanced care pathways, and the current middle aged population of Cumbria should be encouraged to take greater preventative action (e.g. stopping smoking and adopting healthier lifestyles) to promote healthy ageing and reduce the incidence of long term conditions.

- **Support communities to remain independent.** As people generally prefer to remain in their own homes as long as possible, developing services to enable them to do this will be particularly important. Developments in telecare, assistive technology, improved housing and personal budgets will be needed to support this, as well as preventative services to reduce risks from problems such as falls and a review into end of life care.

- **Many more will suffer from dementia.** Delivery of national and local dementia strategies in partnership with local authorities will be a key issue as the prevalence of dementia increases. Cumbria is going to see growing numbers of people with dementia in addition to other long term conditions. This will make management far more challenging.

- **Build capacity through partnership working.** An increasingly ageing population will create demand on health and social care service. Mobilising community assets and increasing joined-up working between the NHS, local authority, and voluntary sector will be needed, and further integration across health and social care will be a key issue across all care pathways.
The purpose of the Joint Strategic Needs Assessment (JSNA) is to bring data on the health needs and people of Cumbria together in one place, to create a picture of the health and service needs and assets of the county and enhance and strengthen the statistical intelligence available to commissioners. This information is then used to support strategic decision making. As an important lever tool to support forward planning, the JSNA 2012-15 will enable us to develop responses to meet the challenges of the future.

This ongoing work programme is the responsibility of all organisations. The JSNA process provides the evidence to clearly show what the key health priorities are. This will underpin our Health and Wellbeing Strategy to be developed in partnership as the next phase in our work to improve health outcomes for all, particularly for the next generation.

The JSNA became a statutory duty for upper tier local authorities and the local NHS in 2008 in recognition that in order to provide the best services and outcomes for communities, strategic planning for health and wellbeing needs to be done in partnership. The Health and Social Care Act, published in January 2011, reaffirms the government’s commitment to the planning and commissioning of health services at a local level, giving the JSNA a nationally enhanced role.

The Health and Social Care Act will lead to significant changes to the way that the NHS is managed and organised. For the NHS, responsibility for commissioning clinical services will move from Primary Care Trusts to NHS Commissioning Boards and local GP led Clinical Commissioning Groups by April 2013.

Responsibility for public health and lifestyle services will move to top tier local authorities (Cumbria County Council) with support from Public Health England.

As national changes to the NHS progress, and Health and Social Care continue to become more integrated, Health and Wellbeing Boards are being introduced as a powerful local mechanism to lead the JSNA, implement actions around key priorities, oversee real change and tackle inequalities.

The Cumbria Health and Wellbeing Board, which will also lead on the development and implementation of the Cumbria Joint Health and Wellbeing Strategy, will bring commissioners together to jointly agree priorities and work together to commission services to improve health and wellbeing outcomes and best meet the needs of the people of Cumbria. This will be supported by an increased focus on user and public engagement through the presence of Healthwatch, a new independent consumer champion created to gather and represent the views of the public.

As health and social care systems undergo major transformation, there are significant opportunities to ensure that the issue of tackling health inequalities is woven into all elements of planning the new system. This will ensure that where an individual is born, educated and raised is a lesser factor in their prospects of a healthy life.

This report highlights four key challenges that are of particular concern for Cumbria. Each of the following areas have been looked at in detail, highlighting key trends, inequalities between areas and communities within Cumbria, comparisons to national averages and implications for the future:

**Challenge 1 – Inequalities**

**Challenge 2 – Children and Young People**

**Challenge 3 – Mental Health and Wellbeing**

**Challenge 4 – Ageing Population**

This report summarises what we know in these four areas, and identifies the implications for the commissioning of services.

Priorities identified through the JSNA and Joint Health and Wellbeing Strategy will involve the public sector, NHS, social care, education, transport, environment and industry in ensuring that we have a unified approach to improving health and social care outcomes in Cumbria.
Achievements and Challenges since 2009

In each challenge within the 2012-15 JSNA, a dashboard of health, social care, wellbeing and inequality measures uses a traffic light rating system to highlight where measures have improved, stayed the same or deteriorated since the previous data set.

The 2009 JSNA identified some similar themes in Cumbria around, for example, an ageing population, health inequalities and mental health issues. Partnerships engaged positively with those challenges, resulting in improvements in number of key indicators, notably:

- % of working age adults with level 4+ or greater education (risen from 23.9% to 30.9%)
- Rate of mortality from circulatory disease <75 (dropped from 77 to 72)
- Mortality rate from suicide and injuries undetermined (dropped from 10.9 to 9.1)
- Infant mortality <1 year (dropped from 4.4 to 3.4)
- Babies born with a low birth weight (dropped from 7.2 to 6.8)
- % of those with disabilities in employment (risen from 46.5 to 49.3)
- % who agree they can influence decision in their area (risen from 29% to 40%)
- % who report drunk and rowdy behaviour as a problem (fallen from 25% to 20%).

Further integration between health and social care has resulted in a number of partnership interventions that are leading to improvements, including:

- Care closer to home. Community services have been reshaped and reinvigorated to reduce reliance on bed based resources. Clinical leadership, Integrated community teams, extra care housing and domiciliary care are allowing people to receive more care closer to home.

- Locality development. Alignment of budgets, short term intervention teams and development of reablement has allowed resources to be focused on the needs to local communities.

- Upstream focus. By focusing on prevention initiatives and supporting patients to become exporters in their own health and care, with greater involvement of the third sector, Cumbria is supporting patients to be in control of their own health and wellbeing.

A challenge since the first Cumbria JSNA was published in 2009 relates to the scale of the national deficit and the resultant austerity measures. This will influence the way we work in the foreseeable future, however it also provides opportunities to meet the needs of individuals in different ways, and target resources to meet the county’s health challenges. Our aim is to tackle health inequalities and fulfil the health and wellbeing needs of the people of Cumbria, including those of vulnerable and seldom heard groups.

Information within the JSNA

The JSNA and supporting resources are part of the work programme of the Cumbria Intelligence Observatory, which brings together research and analysis resources for Cumbria. The partnership includes Cumbria County Council, NHS Cumbria, District Councils, Cumbria Constabulary, Cumbria Fire and Rescue Service, and the University of Cumbria in providing comprehensive data on health and wellbeing in Cumbria and its districts.

The information used to inform decisions about the planning and commissioning of health services falls into four main areas, as show in figure 1.

Figure 1: Types of information used in commissioning services
The wider influences on health and wellbeing such as housing, education or lifestyle behaviours are well known. The JSNA brings data on these health determinants, as well as patterns of health, information on services and aspirations of the public, together as a single source of objective intelligence that has a vital role in evidence based commissioning.

The review of data and information that underpins the JSNA is an ongoing process. Based on the findings of the 2009 Cumbria JSNA, a number of in depth Strategic Needs Assessments have been produced, on topics including:

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

These reports, along with further detailed analysis and resources on all of the topics within this document, as well as locality profiles can be found at www.cumbriaobservatory.org.uk/health/JSNA/2012.asp.

Assessing needs is an on-going process, updates and new information will be added to the Cumbria Observatory website. This will ensure that timely and accurate information informs local commissioning in order to achieve better outcomes for the people of Cumbria.

As well as statistical information, the 2012 JSNA is also complimented by the introduction of ‘asset mapping’, identifying the social, community, and service assets within our county.

Asset mapping identifies the strengths of local areas. Indeed many communities described as “deprived” are extremely “asset rich”. Sometimes these assets go unrecognised because the focus has historically been on measuring need and demand for services, meaning that communities opt to describe themselves in terms of deficits.

Partners across the NHS, local government, the third sector and beyond are now developing a coordinated approach to Asset Based Community Development (ABCD), to gain a better understanding of how communities can work together to create better outcomes.

**Evidence of what works and current services**

Many factors combine to make communities healthier places to live, learn, work, and play. For each health issue and service in Cumbria, a comprehensive review into data, research, service use and gaps must be undertaken to find evidence of what works and identify best practice. The JSNA process identifies key trends, yet research into potential reach and impact on disparities, and other key information such as National guidelines and resources related to effectiveness and implementation, as well as guidelines from the National Institute for Health and Clinical Excellence (NICE) are also needed to inform decision making and support and improvement in health outcomes. This approach is taken within individual health and service needs assessments.

**Engagement and Development Processes**

A Steering Group for the JSNA, with representatives from Children’s Services, Adult Social Care, NHS Cumbria and Cumbria Intelligence Observatory has overseen the production of this report.

In Cumbria we recognise that the process to assess the health and social care needs of Cumbria is iterative and must involve input from all sectors.

A programme of engagement with a wide range of partners was developed early in the design process, in order to promote understanding of the role of the JSNA and elicit information from stakeholders on local assets, resources, priorities and views of local people.
03 Background

Each of the six Local Area Committees in Cumbria were consulted in March 2012, and locality Stakeholder Panels were held in each of Cumbria’s six districts during 2011. These panels were attended by a wide range of health and social care professionals as well as representatives from District Councils, Housing Providers and the Third Sector. A range of information about the health and wellbeing of each district was shared and discussed, including contextual factors relevant to health and wellbeing, and statistics outlining current and future demands on the health and social care system. Further engagement exercises have followed, focusing on the needs of minority and hard to reach groups.

Feedback from participants was used by the JSNA steering group to influence the format of the final document.

A programme of engagement will also follow the publication of the report to inform the JSNA review process.

Local Strategies and Plans

The JSNA is an evidence based document. Cumbria has a robust suite of strategies and plans that underpin the JSNA process and will inform the development of the Health and Wellbeing Strategy.

These include:
- Cumbria Joint Strategic Needs Assessment 2009
- Cumbria Health and Wellbeing Strategy
- Cumbria County Council Plan 2011-2014
- NHS Cumbria Operating framework 2012-13
- The Cumbria Clinical Commissioning Group Draft Commissioning Plan
- Local Authority Community Plans
- The New Cumbria Housing Strategy and Investment Plan 2011 - 2015
- Children’s Services Directorate Plan 2012-2013
- Adult Social Care Directorate Plan 2012-13
- Environment Directorate Plan 2012-13
- Cumbria Child Poverty Strategy 2011-2014
- Wellbeing and Mental Health Strategic Framework for Cumbria 2011-2014

Many of the changes and developments to national and local policy will also have an effect on the future direction and delivery of services, and will influence the development of the Health and Wellbeing Strategy in the short and medium term.

Local and National strategies and the evidence summarised in this report indicate the approach that commissioners need to take to enable Cumbria to meet future challenges.
Cumbria is a diverse county, covering an area of 2,635 square miles with a population of 494,000. Cumbria is the second largest county in England, yet it is also the second least densely populated county, with over 50% of the population living in rural communities compared to 19% in England.

Cumbria is made up of six districts: Allerdale, Barrow-in-Furness, Carlisle, Copeland, Eden and South Lakeland. Each of these areas is supported by a District Council and the County Council.

GP-led boards representing each of the six districts make up the Cumbria Clinical Commissioning Group (CCG). The CCG will soon assume the full responsibility from NHS Cumbria for commissioning hospital, nursing and other local health services in the county.


<table>
<thead>
<tr>
<th>Allerdale</th>
<th>Barrow</th>
<th>Carlisle</th>
<th>Copeland</th>
<th>Eden</th>
<th>South Lakeland</th>
<th>Cumbria</th>
</tr>
</thead>
<tbody>
<tr>
<td>94,100</td>
<td>70,700</td>
<td>104,500</td>
<td>69,500</td>
<td>51,800</td>
<td>103,700</td>
<td>494,400</td>
</tr>
</tbody>
</table>

The county’s largest urban areas are Carlisle in the North of the county - the administrative centre of Cumbria, and Barrow in the South West.

For statistical purposes, the county is split into a set of geographies called ‘super output areas’ (SOAs). The key feature of SOAs is that the boundaries will not change, so data and changes can be monitored over time. Cumbria has 322 lower super output areas (average population 1500), 29 of which are within the 10% most deprived in England and Wales, of which 8 are in the worst 3%. Overall, around 16% of the population live in areas which are amongst the most deprived in the country, yet problems are often masked by statistical averages. Areas of significant deprivation include Barrow in Furness, Carlisle, Cleator Moor, Distington, Frizington, Maryport, Whitehaven and Workington.

Cumbria has an older population than the national average with approximately 19,941 more people aged over 65 than would be expected given the England age profile. The numbers of younger people in the county are also lower than expected, see Figure 2 overleaf.

The large and rural nature of Cumbria presents unique challenges in service design and delivery, with some residents having to travel considerable distances to access essential services such as hospitals, schools and GP surgeries. 70% of settlements have less than 200 residents.

The county has experienced a rise in population since 2001, however growth has been slower that the national trend at 1.4% compared with a growth of 5.6% for England overall.
Cumbria’s population is ageing rapidly, particularly in rural areas. Since 2001, the number of residents aged over 65 has increased by 13.2% compared to a 9.8% rise nationally. In addition, the number of young people aged under 16 has declined in the county over the same time period by 8.8%, compared with a much more modest decline of 1.4% in England. There are indications, however, that the birth rate in the county has begun to increase in recent years. There are now 1,000 more 0-4 year old children in the county than there were in 2003, with a large part of this increase occurring in Carlisle.

The most recent population projections show that by 2035 Cumbria’s population will have grown by 5.7% to 526,000, see Figure 3. This increase is largely a result of people retiring into the county, and people living longer. The population increase is not expected to be evenly spread throughout the county. An 8.1% increase is expected in Carlisle, and only a 2.5% increase in Barrow. This growth is also not expected to be spread evenly across age groups. While the number of residents aged over 65 is projected to increase by 60.5% to 163,000, the number of residents aged 0-15 year olds is projected to fall by -6.4%, see Figure 3.
The proportion of residents from black and minority ethnic (BME) groups is low at 4.9% compared to 17.2% nationally. The district spread of BME population ranges from 3.7% of the population in Barrow to 6.3% of the population in South Lakeland. There has been significant immigration into Cumbria from non-UK nationals, primarily from Poland. This immigration is predominantly associated with the tourist sector in the Lake District, agriculture in rural areas and the seafood industry on the coast.

Cumbria has a relatively large Gypsy and Traveller community. We know that at a national level minority groups experience difficulties accessing health and social care services, therefore in 2009 a comprehensive Health Needs Assessment was carried out by NHS Cumbria. The report uncovered a range of issues associated with inequality within the Gypsy and Traveller population and made recommendations to reduce inequalities experiences by this group.

The small percentage of minority communities in Cumbria makes it statistically difficult to assess whether there is an adverse impact on ethnic minorities from any particular aspects of ill health. Further information on BME and other groups such as lesbian and gay people and people with disabilities is needed to ensure services are meeting the needs of all people across Cumbria.

Social and Place Wellbeing

The health of individuals and communities is dependent on a wide range of factors that contribute to an overall sense of social and place wellbeing. Social determinants including education, high quality housing, levels of unemployment, transport and access to services and a sense of belonging to a community have a major influence on an individual’s health.

Differences in living conditions mean that people in the most affluent areas of Cumbria are living almost 20 years longer than those in more disadvantaged area. Figure 4 overleaf shows the stark differences in the determinants of health and health inequalities between each district.
The average person in Cumbria can expect to live to 79.9 years of age. There is a 19.5 year gap between the wards with the highest and lowest life expectancy in the county.

61,161 (28.1%) of households in Cumbria live in fuel poverty, rising to 38% in Eden. This compares to 18.4% of households in England.

There are 16,570 people in Cumbria on incapacity benefits (excluding Employment Support Allowance).

21.5% of adults in Cumbria smoke.

Less than one third of adults in Cumbria (28.5%) eat five or more portions of fruit and vegetables each day

Barrow is the 3rd most deprived district in England in terms of health and disability compared to Eden which is the 205th.

49% of adults in Cumbria have participated in no sessions of sport and active recreation in the past 28 days.

Around 500 people per year under the age of 75 might be expected to die from Cancer in Cumbria. Mortality rates from Cancer are highest in Carlisle and Allerdale.

321 people per year under the age of 75 might be expected to die from circulatory diseases in Cumbria. Mortality rates from Circulatory disease are highest in Barrow and Copeland.

In 2010 there were 87 GPs in Cumbria per 100,000 of the population, the fourth highest rate in England.

In 2009/2010 out of every 1000 households in Cumbria, 1.8 were classified as statutory homeless.

572 patients in Cumbria waited more than three months to receive treatment during 2009/10.

Only 15% of children in care achieved 5 A*-C grades (including English and Maths) at GCSE compared to the county pass rate of 57%.

99 men and 66 women in Cumbria died from conditions directly caused by alcohol between 2007 and 2009

2,705 crimes in Cumbria were attributable to alcohol consumption during 2010-2011

1,172 people aged 18-75 years were in structured alcohol treatment in Cumbria during 2009-2010

<table>
<thead>
<tr>
<th>Health Inequalities Measures</th>
<th>National Comparison</th>
<th>Trend</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>The average person in Cumbria can expect to live to 79.9 years of age. There is a 19.5 year gap between the wards with the highest and lowest life expectancy in the county.</td>
<td>70,700</td>
<td>104,500</td>
<td>Office for National Statistics, 2007-2009</td>
</tr>
<tr>
<td>61,161 (28.1%) of households in Cumbria live in fuel poverty, rising to 38% in Eden. This compares to 18.4% of households in England.</td>
<td></td>
<td></td>
<td>Department of Energy and Climate Change, 2009</td>
</tr>
<tr>
<td>There are 16,570 people in Cumbria on incapacity benefits (excluding Employment Support Allowance).</td>
<td></td>
<td></td>
<td>NOMIS, May 2011</td>
</tr>
<tr>
<td>21.5% of adults in Cumbria smoke.</td>
<td></td>
<td></td>
<td>North West Public Health Observatory Health Profiles, 2009-2010</td>
</tr>
<tr>
<td>Less than one third of adults in Cumbria (28.5%) eat five or more portions of fruit and vegetables each day</td>
<td></td>
<td></td>
<td>North West Public Health Observatory Health Profiles, 2006-2008</td>
</tr>
<tr>
<td>Barrow is the 3rd most deprived district in England in terms of health and disability compared to Eden which is the 205th.</td>
<td></td>
<td></td>
<td>Indices of Multiple Deprivation, 2010</td>
</tr>
<tr>
<td>49% of adults in Cumbria have participated in no sessions of sport and active recreation in the past 28 days.</td>
<td></td>
<td></td>
<td>Active People Survey 5, Sport England, October 2010-October 2011</td>
</tr>
<tr>
<td>Around 500 people per year under the age of 75 might be expected to die from Cancer in Cumbria. Mortality rates from Cancer are highest in Carlisle and Allerdale.</td>
<td></td>
<td></td>
<td>NHS Information Centre, 2008-2010</td>
</tr>
<tr>
<td>321 people per year under the age of 75 might be expected to die from circulatory diseases in Cumbria. Mortality rates from Circulatory disease are highest in Barrow and Copeland.</td>
<td></td>
<td></td>
<td>NHS Information Centre, 2008-2010</td>
</tr>
<tr>
<td>In 2010 there were 87 GPs in Cumbria per 100,000 of the population, the fourth highest rate in England.</td>
<td></td>
<td></td>
<td>NHS Information Centre, 2010</td>
</tr>
<tr>
<td>In 2009/2010 out of every 1000 households in Cumbria, 1.8 were classified as statutory homeless.</td>
<td></td>
<td></td>
<td>North West Public Health Observatory, 2009-2010</td>
</tr>
<tr>
<td>572 patients in Cumbria waited more than three months to receive treatment during 2009/10.</td>
<td></td>
<td></td>
<td>NHS Information Centre, 2009-2010</td>
</tr>
<tr>
<td>Only 15% of children in care achieved 5 A*-C grades (including English and Maths) at GCSE compared to the county pass rate of 57%.</td>
<td></td>
<td></td>
<td>ChiMat, Cumbria Child Health Profile 2012, data from 2010-2011</td>
</tr>
<tr>
<td>2,705 crimes in Cumbria were attributable to alcohol consumption during 2010-2011</td>
<td></td>
<td></td>
<td>Local Alcohol Profiles England, 2010-2011</td>
</tr>
<tr>
<td>1,172 people aged 18-75 years were in structured alcohol treatment in Cumbria during 2009-2010</td>
<td></td>
<td></td>
<td>Local Alcohol Profiles England, 2009-2010</td>
</tr>
</tbody>
</table>
Although standards of living have improved greatly over the last 100 years in the UK and Cumbria, the benefits have not been experienced equally across our population. Cumbria remains a county of great contrasts. Although health in Cumbria as a whole is about average across a range of measures, life expectancy varies by almost 20 years between the poorest and wealthiest wards. Throughout this JSNA statistics are given at district level wherever possible so we are not lulled into a false sense of security.

This section of the JSNA looks at some of the challenges facing the county in terms of inequalities in health and the wider determinants of health, such as education and housing. Promoting healthy communities and reducing the health gap of the population are key national priorities. To a large extent, it is the conditions in which people are born, grow, live, work and age and our lifestyle choices that determine our risk of developing disease and poor health in the future.

The rainbow model emphasises that promoting and maintaining health is a partnership at every level – between individuals, neighbourhoods, communities, employers, local and national government and other agencies. It is estimated that the annual cost of health inequalities is around £40 billion through lost taxes, welfare payments and costs to the NHS. So in addition to a compelling social justice case there is also a pressing economic case for addressing health inequalities.

These features are known as the ‘determinants of health’ and are illustrated in the rainbow model below:

The policy context

Since the last JSNA was published in Cumbria, the Marmot Review into health inequalities in England has been published (2010). It proposes an evidence based strategy to address the social determinants of health which lead to health inequalities. It draws further attention to the evidence that most people in England aren’t living as long as the best off in society and spend longer in ill-health. Central to the Review is the recognition that disadvantage starts before birth and accumulates throughout life.

This is reflected in the reviews six policy objectives:

1. Giving every child the best start in life
2. Enabling all children, young people and adults to maximize their capabilities and have control over their lives
3. Creating fair employment and good work for all
4. Ensuring a healthy standard of living for all
5. Creating and developing sustainable places and communities

The local strategies and plans that influence the conditions into which people are born, live, work and die are too numerous to outline in this report; however the key areas where local policy can make a difference are:

- Services to support children and families
- Education and employment
- High quality housing
- Promoting healthy lifestyle behaviours.
**Figure 4: Determinants of health and health inequalities between each district**

<table>
<thead>
<tr>
<th>Districts compared to Cumbria</th>
<th>Cumbria Trend and Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1</strong> % working age adults with level 4 or greater education</td>
<td><strong>1</strong></td>
</tr>
<tr>
<td>Allerdale</td>
<td>Barrow</td>
</tr>
<tr>
<td>30.2%</td>
<td>32.8%</td>
</tr>
<tr>
<td>27.7%</td>
<td>28.5%</td>
</tr>
<tr>
<td>15.4%</td>
<td>6.8%</td>
</tr>
<tr>
<td>40%</td>
<td>39%</td>
</tr>
<tr>
<td>22.2%</td>
<td>28.9%</td>
</tr>
<tr>
<td>1957</td>
<td>2528</td>
</tr>
<tr>
<td>18%</td>
<td>25%</td>
</tr>
<tr>
<td>7.2%</td>
<td>12.4%</td>
</tr>
<tr>
<td>27.2%</td>
<td>23.8%</td>
</tr>
<tr>
<td>120%</td>
<td>117%</td>
</tr>
<tr>
<td>75%</td>
<td>86%</td>
</tr>
<tr>
<td>22.3%</td>
<td>30.9%</td>
</tr>
<tr>
<td>£25,319</td>
<td>£22,835</td>
</tr>
<tr>
<td>£156,112</td>
<td>£111,852</td>
</tr>
<tr>
<td>146%</td>
<td>195%</td>
</tr>
<tr>
<td>87%</td>
<td>76%</td>
</tr>
<tr>
<td>18.5%</td>
<td>25%</td>
</tr>
<tr>
<td>69.7%</td>
<td>38.2%</td>
</tr>
</tbody>
</table>

**Key:**
- **Worse than**
- **Similar to**
- **Better than**

---

**Note:**
- The data represents various health and social indicators for different districts compared to Cumbria trends and comparisons. The indicators include education attainment, fuel poverty, excess winter deaths, influence in decision-making, smoking prevalence, hospital admissions due to alcohol, drunk and rowdy behaviour, drug misuse, healthy eating, mortality rates, level of deprivation, median household income, mean house price, crime rates, satisfaction with local area, disability rates, and employment status.

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**Source:**
- Data from various sources, including local government statistics and health surveys.
Inequalities in Cumbria

Poverty is the major driver of the social determinants of health and underpins health inequalities. Addressing poverty will reduce health inequalities.

Nationally, Carlisle and Barrow have been designated as ‘spearhead’ areas as their populations are amongst the most deprived in the English population and experience far worse health than those in wealthier areas. The 20% of people living in the wealthiest areas of Cumbria can, on average, expect to live for six years longer than people living in the most disadvantaged areas. But we should remember that within districts there are stark contrasts in health. Increasingly we need to examine statistics at ward level if we are going to tackle health inequalities. One measure of the social determinants of health is the Index of Multiple Deprivation (IMD). This is a nationally used model that measures multiple domains of deprivation including income, employment, health, education, housing, environment and crime.

In terms of deprivation, Barrow is the 3rd most deprived of 326 Local Authority areas across England, Copeland 29th, Carlisle 59th and Allerdale 70th. South Lakeland and Eden experience much more favourable health outcomes, and are ranked as 138th and 205th respectively. Figure 5 highlights areas of deprivation across Cumbria.

Figure 5: Map showing Cumbria divided into five areas of equal population based on the level of deprivation.

Levels of deprivation are based on the following criteria:
- Crime
- Benefit claimants
- Educational attainment
- Health
- Environmental quality
- Employment
- Access to housing
- Access to services

Those people living in Cumbria’s more disadvantaged areas tend to have the worst health with increased prevalence of heart disease, respiratory disease and other health problems, a poorer quality of life and decreased life expectancy. Deprived areas also tend to experience poorer engagement with, and outcomes from, health and social care services.
Following the fortunes of 400 babies born in Cumbria, 200 from the least deprived part of the county, 200 from the most deprived, if nothing changes local statistics predict that this is what will happen to them.

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

Life expectancy has increased greatly over the last 100 years. The average life expectancy at birth in England has now reached 77.7 years for men and 81.8 years for women. In Cumbria it is similar to the national average at 78 years for men and 81.7 years for women. However, there are striking variations across districts with those living in Greystoke in Eden having a life expectancy of 91.3 years compared to just 71.8 years in Moss Bay in Allerdale (19.5 year gap).

As longevity has increased quality of life has become a more important issue. Variations across the county are evidenced not only in how long people live, but also how many years are spent in good and poor health. Figures 6 and 7 illustrate the differences in both life expectancy and years of healthy life by district. The variation in healthy life expectancy in the county is even wider with a 23.9 year gap between Greystoke in Eden and Central ward in Barrow-in-Furness.

Figure 6: Male life expectancy showing number of years of healthy life

<table>
<thead>
<tr>
<th>District</th>
<th>Not healthy Years</th>
<th>Healthy Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allerdale</td>
<td>65</td>
<td>50</td>
</tr>
<tr>
<td>Barrow</td>
<td>66</td>
<td>49</td>
</tr>
<tr>
<td>Carlisle</td>
<td>67</td>
<td>53</td>
</tr>
<tr>
<td>Copeland</td>
<td>68</td>
<td>55</td>
</tr>
<tr>
<td>Eden</td>
<td>69</td>
<td>56</td>
</tr>
<tr>
<td>South Lakeland</td>
<td>70</td>
<td>57</td>
</tr>
<tr>
<td>England</td>
<td>71</td>
<td>58</td>
</tr>
</tbody>
</table>

Figure 7: Female life expectancy showing number of years of healthy life

<table>
<thead>
<tr>
<th>District</th>
<th>Not healthy Years</th>
<th>Healthy Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allerdale</td>
<td>62</td>
<td>58</td>
</tr>
<tr>
<td>Barrow</td>
<td>65</td>
<td>53</td>
</tr>
<tr>
<td>Carlisle</td>
<td>66</td>
<td>55</td>
</tr>
<tr>
<td>Copeland</td>
<td>68</td>
<td>56</td>
</tr>
<tr>
<td>Eden</td>
<td>70</td>
<td>57</td>
</tr>
<tr>
<td>South Lakeland</td>
<td>72</td>
<td>58</td>
</tr>
<tr>
<td>England</td>
<td>75</td>
<td>58</td>
</tr>
</tbody>
</table>

Premature mortality

Premature mortality, that is death that occurs before reaching your 75th birthday, is a good measure of health inequality. There have been dramatic improvements across Cumbria in the last 25 years with the chances of men surviving to the age of 75 increasing by nearly a half from 47% to 67% and from 66% to 78% in women.

Only a third of deaths now occur before the age of 75. The three big killers in Cumbria are cancer, circulatory conditions such as heart disease and stroke and respiratory diseases such as pneumonia and chronic obstructive pulmonary disease (COPD). Figure 8 shows the number and main causes of early deaths in men and women.

Heart disease is the leading cause of avoidable death. Deaths amongst men under 65 from heart disease are far higher than amongst women.
Figure 8: Major causes of premature death (before age 75) for Cumbria – 2008 to 2010

- Neurological including Dementia: 179 (3%)
- Cancer: 2204 (41%)
- Heart Disease, Stroke: 1409 (26%)
- Accidents and Suicides: 346 (7%)
- Diseases of Respiratory System: 472 (9%)
- Digestive System including Alcohol: 344 (6%)
- Other Causes of Death: 407 (8%)
- Other Causes: 407 (8%)
- Digestive System including Alcohol: 344 (6%)

Figure 9: Premature mortality from all circulatory disease: Directly standardised rate per 100,000 population

Figure 9 shows the premature death rates from circulatory diseases (heart disease and stroke) across the districts over the last 15 years. Although death rates have been falling in Cumbria as they have nationally, the contrast between districts is striking. The gap between Barrow, with the highest mortality, and South Lakeland with the lowest mortality, is starting to narrow.
Figure 10 shows the premature death rates from cancer across the districts over the last 15 years. Again, the contrast between districts is striking.

Many factors contribute to health; however deprivation is a leading cause of ill health and premature death. Figure 11 shows the premature death rate in areas across Cumbria and grades them using a traffic light system, where red indicated that deaths are significantly higher in these areas. The distribution of premature deaths by deprivation is evident.
Figure 11: Premature Mortality, All Causes, persons, 2008-10 by electoral ward
Lifestyle and behaviours

Evidence shows that those from more disadvantaged backgrounds are more likely to adopt unhealthy behaviours such as smoking, poor nutrition, low levels of physical exercise and problematic drug or alcohol use, all of which give rise to poor health – particularly heart disease, stroke and cancer.

Smoking is the single biggest avoidable cause of premature death in Cumbria. On average, over 900 people die each year in Cumbria because they smoke.

Smoking is not only linked with lung cancer; it also plays a part in other cancers, including bladder cancer, kidney cancer, stomach cancer, pancreatic cancer and oesophageal cancer.

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

Being obese can lead to a number of serious health problems, as well as shorten life expectancy. It is estimated that 7% of all deaths each year in England are due to obesity. Being overweight puts people at risk of a number of health problems, including high blood pressure, which is a major risk factor for developing heart disease, type 2 diabetes, and stroke.

As the below graphs show, lifestyle and behaviours are different through the county.
Estimated smoking prevalence

Hospital admissions due to alcohol

Estimated prevalence of drug misuse (crack and opiates) per 1000 people

Healthy eating among adults (5 or more portions of fruit and veg a day)
Housing

Housing and the condition of someone’s home is a key influence on a person’s health and wellbeing. Living conditions affect health in a variety of ways which could see inequality spiral.

A cold and damp home can exacerbate respiratory conditions, a property that is in poor condition may be detrimental to mental wellbeing, whilst a home in poor repair has the potential to increase falls and accidents.

Cold and damp homes are implicated in one in 20 deaths and strongly linked to illnesses such as heart attacks, chest infection and stroke.

We know that our deprived areas, where residents may have the lowest levels of choice, are the ones with the highest market failure rates and the poorest quality stock. This becomes worse in times of recession when choice becomes limited adding to the potential for poorer health and greater inequality.

The quality of housing within Cumbria is mixed, with high levels of substandard housing in both Copeland and Barrow-in-Furness districts. In Barrow-in-Furness over half of the housing stock predates 1919 and 14% of dwellings are classified as dangerous (having a category one hazard). This compares to 8% in England. 25% have a category one hazard in Allerdale, 16% in Carlisle, 26% in Copeland and 27% in Eden.

Social rented housing in most cases is at the ‘Decent Homes’ standard but there remains a problem in the private rented sector, which is growing as a proportion of the housing mix in Cumbria. With reduced public sector funding, there will be an increasing reliance upon the private sector to deliver an attractive open market housing offer and to support the need for affordable housing.

Across the districts there is a need for housing market renewal, affordable housing and the need for specialist housing such as sheltered housing to cope with the demands of an ageing population.

Targeted health campaigns

Deprived areas of Cumbria have higher rates of lung cancer and lower survival rates than the average. A 2010 survey of cancer awareness in these areas suggested that a lack of awareness of the early warning signs of cancer and fears over what the doctor might find were preventing people with symptoms from going to their doctor.

A ‘Cough, Cough’ campaign was launched in 2011. Local lung cancer survivors fronted the campaign urging people to go to their doctor if they had had a cough for more than three weeks. The project was targeted at the priority areas of Carlisle, West Cumbria and Furness.

The campaign led to an increase in presentations to GPs, an increase in referrals for chest x-rays and an increase in lung cancer diagnoses. The campaign will be repeated in 2012 and lessons from the campaign will also be used to inform a dementia awareness campaign that is being developed.

“If you’ve had that cough for 3 weeks, get down to your doctor. The sooner the better.”

Cumbria has one of the highest rates of lung cancer in the UK and has the highest number of deaths from the disease.
Reducing inequalities

Work on reducing health inequalities has not made the impact that has been expected. While there is a wealth of evidence about which groups and populations suffer poorer health and what the risk factors are, there is little information on how best to act to reduce the gap and improve health and wellbeing.

Life expectancy rates are increasing overall but they are rising faster in affluent areas than in areas of higher deprivation. This means the gap is actually getting wider.

Much has been done to raise awareness of behaviour related health risks through lifestyle campaigns on issues such as smoking, alcohol and healthy eating, but improved knowledge alone does not change behaviours, many of which are set in formative years.

There is evidence that the impact of social marketing messages are different for different social groups and economic status, meaning a variety of approaches are needed to effect any real change.

Some of the strongest influences on behaviour change are family and neighbours, a sense of coherence and a collective sense of self esteem, helping people believe that it is possible to take actions to improve health and wellbeing, which is why the involvement of patients and service users remains a priority for commissioners.

Key considerations for commissioners

The scale of the challenge to reduce inequalities is enormous. Action to reduce inequalities requires a coordinated effort across the public and private sector.

Cumbria has a strong commitment to tackling health inequalities and an increasing focus on collaborative action. An agreed performance framework supports this, helping to drive an increase in the pace and focus of work to level up the worst performing areas to those of the best. However, there remains a need for clarity as to what current and future initiatives across partners are, and how they will contribute to a reduction in health inequalities across Cumbria.

The next stage is for partners to agree specific actions and objectives and to systematically embed these into key thematic strategies.

When planning services, commissioners and service planners need to consider the different outcomes for communities across the county, remembering to:

- **Build a health and social care system based on good intelligence.** The JSNA is an ongoing process. A robust intelligence service, joined up across all public sector organisations and accessible to all, can provide an evidence based system for identifying improvements, establishing options and targeting services that lead to better health and social care systems.

- **Use all available resources.** All public and private organisations must work together to build capacity and improve health and wellbeing. In particular, given that smoking is a major factor in premature mortality and health inequalities, all public, private and 3rd sector organisations should play a part in helping people to quit. ..

- **Involve our communities and the voluntary sector.** There must be a strong emphasis on public health initiatives, public engagement, self management and a continuation of the commitment to orientate services closer to home to enable our citizens and communities to self manage and be in control of their own health outcomes. There is also a need for more systematic engagement with the voluntary sector which can be a real engine for innovation.

- **Recognise inequalities in all work programmes.** By explicitly recognising the impact that factors such as employment and skills, transport, recruitment, procurement, community engagement, facilities management, economic development and regeneration have on health – the public sector can begin to address inequalities and improve health and wellbeing.
## 06 Challenge 2 – Children and Young People

<table>
<thead>
<tr>
<th>Children and Young People in Numbers</th>
<th>National Comparison</th>
<th>Trend</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>16,702 (15.4%) of children in Cumbria live in poverty. This varies from 21.8% in Barrow to 8.9% in South Lakeland.</td>
<td></td>
<td></td>
<td>HMRC, 2009</td>
</tr>
<tr>
<td>The number of young people in Cumbria is forecast to fall by 6.4% by 2035.</td>
<td></td>
<td></td>
<td>2010 ONS Sub National Population Projections</td>
</tr>
<tr>
<td>In Cumbria between 2008 and 2010, 52 babies died before their first birthday (infant mortality rate)</td>
<td></td>
<td></td>
<td>NHS Information Centre, 2008-2010</td>
</tr>
<tr>
<td>56% of 16 years olds in Cumbria achieved 5 A*-C grades at GCSE including English and Maths just below national levels.</td>
<td></td>
<td></td>
<td>Cumbria Children’s Services 2011</td>
</tr>
<tr>
<td>On average out of every 1000 teenage girls aged 15-17 years in Cumbria 37 will become pregnant.</td>
<td></td>
<td></td>
<td>Office for National Statistics and Department for Education, 2008-2010</td>
</tr>
<tr>
<td>328 (6.8%) of babies born in Cumbria weighed under 2.5kg</td>
<td></td>
<td></td>
<td>NHS Information Centre, 2010</td>
</tr>
<tr>
<td>9.7% of reception year children and 20.8% of year six children in Cumbria are obese.</td>
<td></td>
<td></td>
<td>National Child Measurement Programme, 2010-2011 school year</td>
</tr>
<tr>
<td>69% of new mothers in Cumbria begin breastfeeding.</td>
<td></td>
<td></td>
<td>Cumbria Child Health Profile 2012, ChiMat, data from 2010-2011</td>
</tr>
<tr>
<td>15% of expectant mothers continued to smoke during pregnancy.</td>
<td>N/Av</td>
<td>N/Av</td>
<td>Cumbria Primary Care Trust Maternity Databases, Q1, Q2 and Q3 2011/12</td>
</tr>
<tr>
<td>60% of school children in Cumbria participate in three hours or more of high quality PE and sports per week</td>
<td></td>
<td>N/Av</td>
<td>NWPHO, Health Profiles, 2009-2010</td>
</tr>
<tr>
<td>Almost 95% of Cumbrian children received their MMR immunisation by their second birthday compared to 89% in England.</td>
<td></td>
<td></td>
<td>Cumbria Child Health Profile 2012, ChiMat, data from 2010/11</td>
</tr>
<tr>
<td>2,300 (2.6%) children with a severe disability are receiving disability living allowance in Cumbria</td>
<td></td>
<td></td>
<td>Annual Population Survey February 2011</td>
</tr>
<tr>
<td>48% of females and 50% of males in year 10 in Cumbria report drinking alcohol in the past week</td>
<td>N/Av</td>
<td>N/Av</td>
<td>Health Related Behaviour Survey 2010</td>
</tr>
<tr>
<td>By age 12 the average child in Cumbria has one decayed, missing or filled tooth.</td>
<td></td>
<td>N/Av</td>
<td>Cumbria Child Health Profile 2012, ChiMat, data from 2008/09</td>
</tr>
<tr>
<td>On average 26 children aged 0-15 years are killed or seriously injured in road traffic accidents in Cumbria per year.</td>
<td></td>
<td></td>
<td>Cumbria Child Health Profile 2012, ChiMat, data from 2008-2010</td>
</tr>
<tr>
<td>6.7% of people aged 16-24 years in Cumbria are claiming job seekers allowance over double the rate of the working age population as a whole.</td>
<td></td>
<td></td>
<td>Cumbria Intelligence Observatory Labour Market Briefing, March 2012</td>
</tr>
</tbody>
</table>

Key: **Worse than**  **Similar to**  **Better than**
It is the experience, life chances and habits developed in early years that often shape the future health outcomes later in life, making the health of our younger population a priority. Our children and young people are the parents, carers and workforce of tomorrow. Some of them are already carers today.

The wider social and economic determinants that affect the health and wellbeing of children and young people in Cumbria are the same as in other parts of the North West with local variations between districts.

A child’s health and development, both early and in later life, are heavily influenced by a range of factors, including:

- Maternal health and maternal behaviours, especially smoking and nutrition before, during and after pregnancy.
- Nutrition in early years, including breastfeeding, has a significant influence on later outcomes and life chances. Some outcomes of poor nutrition and smoking include infant deaths, diabetes, respiratory conditions and obesity.
- Positive family dynamics, both in level and quality of support and role models.
- Behaviours. Smoking, alcohol and drug use, poor diet and lack of physical exercise all contribute to ill health and diseases.
- Deprivation. Children growing up in poverty are more likely to have worse physical and mental health and do less well at school.

In Cumbria, 2,460 children are receiving social care services with 25.5 children’s social care users per every 1000 children aged 0-17 years. The rate of children’s social care users is highest in Barrow-in-Furness at 33.2 and lowest in South Lakeland at 14.3.

**Children and Young People: Future Trends**

Far fewer babies are born in Cumbria than England. Cumbria’s birth rate is 10 per 1000, where England’s rate is 12.5 per 1000.

There are over 108,454 children and young people aged 0 to 19 years living in Cumbria. The number of young people aged 0-15 is forecast to fall by 6.4% by 2035. The population decline among 0-15 year olds is greatest in Copeland at 10.1 followed by South Lakeland at 7.9, see Figure 12. Of all county councils, Cumbria is projected to have the largest decline in people aged 0-15 by 2035.

**Figure 12: Projected Change in the Population aged 0-15 years between 2010 and 2035 ONS Subnational Population Projections**
The health and wellbeing of Cumbria’s children and young people was identified as a challenge in the 2009 JSNA. Issues and inequalities remain.

The priorities of Cumbria’s Children’s Trust Board for 2012/2013 are:

- No avoidable child deaths
- No children living in poverty
- All children are ready for school at age 5
- Young people are ready to be proactive, productive citizens at 16
- Children and young people respect and value themselves and each other

Cumbria County Council’s underpinning aspirations most pertinent to children and young people are:

- A great place to be a child and grow up
- A place to enjoy an independent and healthy life.

Local plans to inform commissioning decisions for children and young people include:

- Children’s Services Directorate Plan 2012-2013

Supporting vulnerable young parents

To support young parents, the Family Nurse Partnership Programme began in Cumbria in January 2009. ‘Family nurses’ work with first time parents aged 19 years and under from the second trimester of pregnancy until the child is two, giving home visits to improve antenatal and child health. The programme focuses on providing intensive support on child development and school readiness while also linking the family to wider social networks and employment.

The early indicators are showing a reduction in risk taking behaviours in the young parents, increased uptake of breast feeding, a very good gestational age at birth and good birth weights, low attendances at A&E, and clients returning back to education or commencing work and enhanced developmental milestones for the child.
### Figure 13: Children and Young People

#### Districts compared to Cumbria

<table>
<thead>
<tr>
<th></th>
<th>Allerdale</th>
<th>Barrow</th>
<th>Carlisle</th>
<th>Copeland</th>
<th>Eden</th>
<th>South Lakeland</th>
</tr>
</thead>
<tbody>
<tr>
<td>1% Children living in poverty</td>
<td>16.5%</td>
<td>21.8%</td>
<td>16.9%</td>
<td>17.8%</td>
<td>9.2%</td>
<td>8.9%</td>
</tr>
<tr>
<td>2% of mothers smoking during pregnancy</td>
<td>13.7%</td>
<td>23.2%</td>
<td>15.2%</td>
<td>14.2%</td>
<td>13.5%</td>
<td>10.9%</td>
</tr>
<tr>
<td>3% children participating in PE</td>
<td>60.3%</td>
<td>71%</td>
<td>56.7%</td>
<td>54.5%</td>
<td>60.6%</td>
<td>58.0%</td>
</tr>
<tr>
<td>4% of year six children obese</td>
<td>21.7%</td>
<td>20.3%</td>
<td>20.3%</td>
<td>23.9%</td>
<td>23%</td>
<td>17.3%</td>
</tr>
<tr>
<td>5 Infant mortality per 1000 births</td>
<td>3.0%</td>
<td>3.4%</td>
<td>2.7%</td>
<td>4.5%</td>
<td>2.1%</td>
<td>4.6%</td>
</tr>
<tr>
<td>6% born with low birth weight (&lt;2.5kg)</td>
<td>6.8%</td>
<td>6.4%</td>
<td>6.6%</td>
<td>8.4%</td>
<td>5.7%</td>
<td>7.0%</td>
</tr>
<tr>
<td>7 Teenage pregnancy rate (aged 15-17)</td>
<td>42.9%</td>
<td>38.6%</td>
<td>52.7%</td>
<td>38.2%</td>
<td>26.4</td>
<td>21.9%</td>
</tr>
<tr>
<td>8% of 0-16 entitled to disability living allowance</td>
<td>2.5%</td>
<td>3.6%</td>
<td>2.3%</td>
<td>2.9%</td>
<td>2.2%</td>
<td>2.2%</td>
</tr>
<tr>
<td>9% of pupils achieving 5 A*-C grades (including English and Maths)</td>
<td>57.5%</td>
<td>52.0%</td>
<td>52.5%</td>
<td>48.0%</td>
<td>64.4%</td>
<td>64.4%</td>
</tr>
<tr>
<td>10% of babies still being breastfed at 6 to 8 weeks</td>
<td>34.4%</td>
<td>27.6%</td>
<td>26.5%</td>
<td>26.7%</td>
<td>48%</td>
<td>48%</td>
</tr>
</tbody>
</table>

#### Cumbria Trend and Comparison

<table>
<thead>
<tr>
<th></th>
<th>Cumbria</th>
<th>Trend</th>
<th>Compared to North West</th>
<th>Compared to England</th>
</tr>
</thead>
<tbody>
<tr>
<td>1% Children living in poverty</td>
<td>15.4%</td>
<td>Similar to</td>
<td>23.1%</td>
<td>21.3%</td>
</tr>
<tr>
<td>2% of mothers smoking during pregnancy</td>
<td>15.3%</td>
<td>No data</td>
<td>No data</td>
<td>No data</td>
</tr>
<tr>
<td>3% children participating in PE</td>
<td>59.8%</td>
<td>No data</td>
<td>No data</td>
<td>No data</td>
</tr>
<tr>
<td>4% of year six children obese</td>
<td>20.8%</td>
<td>Deteriorating</td>
<td>19.7%</td>
<td>19%</td>
</tr>
<tr>
<td>5 Infant mortality per 1000 births</td>
<td>3.4%</td>
<td>Improving</td>
<td>4.9%</td>
<td>4.6%</td>
</tr>
<tr>
<td>6% born with low birth weight (&lt;2.5kg)</td>
<td>6.8%</td>
<td>Improving</td>
<td>7.2%</td>
<td>7.3%</td>
</tr>
<tr>
<td>7 Teenage pregnancy rate (aged 15-17)</td>
<td>37.4%</td>
<td>Similar to</td>
<td>43.5%</td>
<td>38.1%</td>
</tr>
<tr>
<td>8% of 0-16 entitled to disability living allowance</td>
<td>2.6%</td>
<td>Similar to</td>
<td>2.9%</td>
<td>2.8%</td>
</tr>
<tr>
<td>9% of pupils achieving 5 A*-C grades (including English and Maths)</td>
<td>56.3%</td>
<td>Improving</td>
<td>No data</td>
<td>57.9%</td>
</tr>
<tr>
<td>10% of babies still being breastfed at 6 to 8 weeks</td>
<td>33.6%</td>
<td>Improving</td>
<td>34.2%</td>
<td>47.0%</td>
</tr>
</tbody>
</table>

**Key:**

- **Worse than**
- **Similar to**
- **Better than**
Health and social care challenges for children and young people

Healthy Weight and Nutrition

The rising tide of obesity is one of the greatest threats to health in the UK. In Cumbria, as in the rest of the UK, we have access to food and ready-made meals and snacks practically 24 hours a day and we lead less physically active lives. The UK now has among the highest proportion of children who are overweight or obese in Europe. Childhood obesity is increasing in Cumbria and there is a clear social gradient - with higher levels of obesity among children living in areas of relative deprivation. The Foresight Report, an important government report on obesity, has estimated that by 2050 50% of adult women and 60% of adult men will be obese. Obese teenagers often go on to be obese adults. It is vitally important to address obesity at a young age as it is much more difficult to make lifestyle changes later in life.

Since 2007, the prevalence of obesity has increased in Year 6 in all of the six districts across the County, with the highest increases in Copeland where 24% of Year 6 children were obese in 2010/2011, and Eden where 23% of year 6 children were obese in 2010/2011, see Figure 14.

Breastfeeding is linked to healthy weight in children. Data on breastfeeding has been incomplete in Cumbria but is now improving. It shows that although 69% of babies are breastfed at birth, the proportion drops dramatically over the next few weeks and, for example, by 6 – 8 weeks only 26.5% of infant’s are breastfed in Carlisle. Research has shown that if all babies in Cumbria were breastfed, 60 fewer babies would be admitted to hospital with diarrhoea and there would be 60 fewer admissions with respiratory problems each year.

Obesity and poor diet and nutrition are risk factors for many diseases such as diabetes, heart disease and cancer. Additionally, childhood obesity can result in children having low self-esteem and being bullied. In a Cumbria wide survey of more than 600 Year 6 pupils (aged 10 and 11), 21% reported they were bullied because of their size or weight.

Figure 14: Percentage of obese pupils 2010/11
Risk taking behaviour

Adolescence is the time when young people start to make decisions about how they live. Opportunities arise to engage in what is known as ‘risky behaviour’ such as smoking, drinking alcohol, engaging in sexual activity and experimenting with drugs. The teenage years are the time when attitudes and beliefs that will influence health related behaviour for a lifetime become established so it is important to keep teenagers on the right track.

Cumbria’s Health Related Behaviour survey has provided data on young people’s behaviour for more than 20 years.

Smoking

Young people who live with smokers are more than twice as likely to smoke compared to those living in non smoking households. Surveys have shown that the average age that pupils take up smoking is 13 years old (school Year 8) and girls are more likely to be regular smokers than boys (18% versus 13%). Nearly a third (30%) of 16 to 24 year olds in Cumbria smoke which is similar to the national picture. There is considerable variation between districts, with the highest rates in Copeland (40%) and lowest rates in South Lakeland (14%). Tackling smoking in young people is vitally important as the evidence is clear – children who are not smoking regularly in their teens are unlikely to smoke in adult life.

Alcohol

Harmful drinking is a cause of early death and a major risk factor for mental health disorders, cirrhosis of the liver, heart disease and many cancers, as well as injuries due to road traffic accidents and violence that particularly tends to involve young people. Repeated drunkenness is also associated with smoking, drug use, unsafe sexual activity and anxiety disorders. Studies have shown that family structure and parenting are key influence in moderating alcohol consumption in young people. The availability of extra-curricular activities and the dynamics of local neighbourhoods can also have a significant influence on young people’s drinking behaviour.

Boys are generally more likely to drink alcohol up until age 15 when rates become equal in boys and girls. Amongst 15 to 16 year olds in Cumbria, 12% of boys and 7% of girls said that they had drunk 21 or more units of alcohol in the week before the Cumbria survey. The most common place for drinking was at home or at a friend’s house (38%) and alcohol was most likely to be obtained from parents (18%) or a friend or relative (17%). Hospital admission rates among under 18 year olds for alcohol related conditions in Cumbria are the 4th highest in the 11 primary care trust areas most similar in England.

Substance misuse

Starting to use drugs at a young age can lead to educational under-achievement and problem drug use and ill health in adulthood. Surveys across England have found that among 11 – 15 year olds, smoking cannabis is the commonest form of drug use (9%), followed by glue, gas or other volatile substances (5.5%). 3.6% of pupils had taken a Class A drug such as cocaine or ecstasy in the last year.
Cumbrian surveys show that 2% of primary pupils and 18% of secondary pupils had been offered cannabis. 13.4% of 10 to 15 year olds reported substance misuse compared to 12.9% in the North West region and 10.6% in England.

Among those aged 15-24 years, Cumbria’s hospital admission rate for substance misuse is significantly worse than the national average, with 119.3 admissions per 100,000 compared to the rate of 63.5 for England.

**Sexual health and teenage pregnancy**

Risky sexual behaviour increases the chance of unplanned pregnancies and can lead to sexually transmitted infections. England has the highest rate of conceptions and births amongst teenagers in Western Europe; although there is no evidence that young people become sexually active at a younger age in England than elsewhere. Teenage pregnancy is associated with a number of negative outcomes:

- Babies are 25% more likely to be low birth weight which is associated with poorer health throughout life
- The infant mortality rate is 60% higher than in older mothers
- Teenage mothers are three times more likely to smoke in pregnancy
- Teenage mothers are half as likely to breastfeed
- Teenage mothers are three times more likely to develop post-natal depression

- Teenage parents are less likely to complete their education or training and more likely to bring up their child in poverty

A strategic review of sexual health needs and services undertaken in Cumbria in 2010 showed that 89% of 12-20 year olds felt confident they would know where to go if they were worried about their sexual health. 59% would like to have access to more information about sexual health, particularly through educational talks. Encouragingly, 80% of young people identified a link between alcohol and sexual health, citing reasons such as loss of control and lack of good judgement, leading to increased sexual activity. Data for Cumbria shows that:

- During 2008-2010, per 1000 women aged 15-17 the conception rate was 37.4. This is below the rate for both England and the North West at 38.1 and 37.4 respectively.
- Between 2008-2010 Carlisle district had the highest number of conceptions among women aged 15-17 at 295 followed by Allerdale (228) and Barrow (168). During the same time period there were 199 conceptions among girls aged 13-15 in Cumbria.

- Since the national Teenage Pregnancy Strategy was launched in 1999, the teenage pregnancy rate among women aged 15-17 in Cumbria have fallen from 41 per 1000 to 37.4. This represents a reduction of 8.8%. However, like most other regions Cumbria has failed to meet the ambitious target that was set of halving teenage conceptions by 2010.
Exposure to unintentional injury

Accidental injury is one of the biggest single causes of death for children aged 1-15 years and is closely linked to deprivation. Accidents in the home include burns or scalds, with hot drinks being the most frequent cause of injuries.

- There is significant concern in relation to the numbers of young drivers who are killed and seriously injured in road traffic accidents. Between 1st January 2010 and 31st December 2011, data from Cumbria Police shows that eight young people were killed and 120 were seriously injured.
- Road traffic casualty rates in children under 16 show that Barrow has the 3rd highest rate amongst 408 district council areas in between 2004-08, with Copeland ranked 23rd, Carlisle 40th, Eden 96th, Allerdale 125th and South Lakeland 163rd.
- The number of people killed and seriously injured on Cumbria’s roads reduced by 15.6% between 2008 and 2010.

Assertive Alcohol Outreach

In 2010, a pilot project to establish an outreach service for young people at risk of harm due to alcohol misuse launched in West Cumbria. It was hosted by the then Connexions service, who worked closely with the police and Accident and Emergency staff at the West Cumberland Hospital to target those at risk.

When a young person under 18 presented at A&E or was identified through the ‘Pubwatch’ scheme, an Alcohol Outreach Worker would make contact with the young person and where possible their parents and carers with 48 hours. Advice and support would be offered to the child and their parents, and if appropriate, a referral was made to other services including specialist drug and alcohol services. The service was popular with parents and young people, and fewer than 3% refused a home visit.

Following the pilot, there was a reduction in the number of alcohol related hospital admissions and a reduction in the number of young people with repeat attendances at A&E. The numbers accessing specialist support services also increased.

As well as supporting young people to reduce harmful drinking the aim is also to provide a clear pathway from universal through targeted to specialist services for those most vulnerable.

The Assertive Alcohol Outreach service is now being rolled out across the whole of Cumbria.
**Vulnerable Groups**

Some children and young people can be particularly vulnerable to poor health and social care outcomes in general, including:

**Looked After Children**

Children and young people come into care for a variety of reasons including physical harm, neglect, sexual abuse, parental alcohol and drug misuse and issues regarding a parent’s mental health or learning disability which prevents them from providing care to their child.

- At 31st December 2011, Cumbria had 564 Looked after Children.
- Between June 2011 and December 2011 there was an increase of over 8%. Numbers are now at their highest level since before 2004.
- 52% of Looked After Children are aged 10 or over, with 41% aged between 1 and 9 years and the remaining 7% under 1 year.

**Young Carers**

There are currently 576 young carers registered in Cumbria. Many more are not registered.

Young carers are at risk of school absence and under-achievement and poor health both physically and in terms of mental wellbeing. Their caring role often means they need additional support and they commonly experience social isolation and bullying.

**Children with learning difficulties and disabilities**

- 645 primary school pupils in Cumbria have a statement of special educational need and 2315 receive ‘school action plus’, where the school will provide additional support and other services outside of schools are also involved, such as speech and language therapy, educational psychology and/or a children’s centre providing parenting support.
- In secondary schools and academies 805 pupils have a statement of special education need and 947 have ‘school action plus’.
- Across the special educational provision all 455 pupils have a statement of special educational needs.
- In Cumbria 2.6% of young people have a disability however the level is highest in Barrow at 3.6%.
- Over recent years, both children’s and adult services across health, education and social care have become aware of increasing numbers of individuals diagnosed with autism. It is estimated that 18% of the population is on the autism spectrum. This equates to a predicted population of approximately 4800 in Cumbria.
- A large number of people with autism also have other conditions, the most common being learning disability, epilepsy, mood disorders and Attention deficit hyperactivity disorder (ADHD). This has implications for the identification of autism in people who are not yet diagnosed as well as for the need for both conditions to be managed concurrently.
- The percentage of young people with a disability in Cumbria is just below the national average at 2.6%. Barrow-in-Furness has the highest level of young people with a disability at 3.6%.
- There is a lower life expectancy within the learning disability population than the general population and people with a learning disability are more likely to have undiagnosed long term conditions.
- Work needs to continue to identify any ‘reasonable adjustments’ needed at health services to reflect the specific needs of people with a learning disability.

**Safeguarding**

- There were over 6500 incidents of domestic violence reported to the police in Cumbria in 2011, a 15% increase on the previous year. 41% of incidents had repeat perpetrators and it is predicted that around 60% remain unreported.
- A snap shot of 15 child protection case conferences in Cumbria found that 13 involved domestic abuse and domestic violence as a significant factor. The Independent Domestic Violence Advisor Service identified 495 children as being affected by severe domestic violence in 2010/11.
- In Cumbria 867 drug users in treatment live with children for all or some of the time and a further 147 are parents but do not live with their children.
Cumbria Children’s Services currently support 1363 ‘children in need’, 182 of whom have either a learning difficulty and/or disability. 275 children have a ‘child protection’ plan. (November 2011).

Not in Education, Employment or Training (NEET)

- There are more than 800 young people (5%) between 16 and 18 are not in education, employment or training in Cumbria, this is lower than the rate in England.

Health inequality and child health

Childhood poverty and inequalities, as well as the wider determinants of health are all associated with a number of negative outcomes, for example smoking, mortality from cancer, circulatory disease and coronary heart disease. Education, housing, income, work, transport and social networks are all prerequisites for the health of our younger generation.

Although not formally statistically significant it is possible to show that the pupils in areas of high child poverty progress at a lower rate, from Early Years through to Key Stage 4.

Differences in health outcomes in deprived areas of Cumbria are marked, see Figures 4, 5, 9, 10 and 11.

Emotional and Mental Wellbeing

Half of those with lifetime mental health problems first experience symptoms by the age of 14 and three-quarters before their mid-20s.

Around 19,000 children and young people in Cumbria are at risk of poor mental health due to life events such as bullying, bereavement, divorce or serious illness.

Some children and young people are at greater risk of developing problems – including those in care and children and young people with a learning disability. Lesbian, gay and bisexual young people are at greater risk of self harm and teenage mothers are three times more likely to suffer postnatal depression. In addition, rurality has also been identified as a contributor to poor mental health and wellbeing. 28% of Cumbria’s young people live in rural communities.

Cumbria has a higher rate of suicide and self harm amongst the 0-17 year age range than nationally, with 1-2 suicides per year and 220 Accident and Emergency attendances for self-harm. The true number of those who self harm is unknown as there are large numbers of hidden self harm incidence.

The numbers of referrals to the Child and Adolescent Mental Health Services (CAMHS) continues to rise, see Figure 15. This presents a challenge to accessing intervention programmes following initial assessment in some parts of the county.

Figure 15: Number of referrals to Specialist CAMHS 2010/2011

- Allerdale and Copeland
- Carlisle and Eden
- Furness and South
Improving Mental Health and Resilience in Schools

To support schools to engage with pupils on mental health issues and resilience, the Targeted Mental Health in Schools Project saw a team of 8 workers seconded from Children’s Services and the NHS CAMHS services to give direct support to 18 schools across the county. They provided training and consultations for school staff, group work and one to one support for students and workshops for parents. Other partners, for example Action for Children, were also involved in supporting families to understand the importance of early intervention and building resilience into their daily lives.

The project enabled school staff to gain confidence in tackling mental health issues. This has led to improvements in the emotional health and wellbeing of students. The Targeted Mental Health in Schools Project and toolkit will be offered to all schools in 2012 supported by training sessions delivered by the Children’s Health and Wellbeing Team.

Hospital admissions

Cumbria has relatively high levels of emergency paediatric admissions, as shown in Figure 16. All the districts have higher admission rates than the national average and the rate in Barrow is one of the highest in the country. To support a reduction in admissions, care pathways for six key priority areas are being reviewed for children; constipation, fever, acute respiratory, emotional and wellbeing, autism and attention deficit hyperactivity disorder (ADHD).

Figure 16: Paediatric Emergency Admissions Q3 2010/11 Annual Rate
Views of service users

By using a ‘parent participation’ model, parents and professionals are working together to design, develop and improve services for children young people and their families.

Parents have been particularly keen to get involved in service planning and decision making so that services meet the needs of families and resources are not wasted on services which parents and families do not take up.

Feedback from children, young people and families shows:

- Alcohol education and the reduction of extreme risk taking behaviour was a priority for young people
- There is a need to reduce teenage pregnancy
- The relationship between young people and their communities was an area that was highlighted as important in all of the districts
- There is a need for services that raise self esteem, confidence and aspirations
- Career advice and skills services need development
- Parents and carers of children and young people with disabilities have long expressed the view that needs are not responded to in a timely way and that there needs to be significant improvement in the level of integration between health and other services.

Key considerations for commissioners

Historically, services for children, young people and their families in Cumbria have been subject to ad hoc development and review. A priority for Cumbria is to ensure greater coordination and integration of services to improve care and deliver better outcomes and ensure a smooth transition into services for adults.

When planning services for children and young people, the key points for commissioners and service planners to consider are:

- **Ensure children get the best start in life.** Experience, life chances and habits developed in the early years shape future health outcomes later in life. Continued support needs to be given to maternal health and maternal behaviours, especially smoking and nutrition before, during and after pregnancy, and nutrition in early years, including breastfeeding.

- **Prioritise lifestyle improvement, particularly around obesity.** Lifestyle and behaviours such as smoking, alcohol and substance misuse in children all have a significant influence on later health outcomes and life chances. In particular, given that obesity is a risk factor for so many diseases, action to reduce childhood obesity will prevent significant ill health in the Cumbrian population in the future, as well as avoiding the financial costs associated with treating conditions linked to obesity.

- **Integrated services and partnership working.** Given the impact of the social and economic determinants on children’s health, partnership working between the NHS, local authority, voluntary sector and other partners to tackle these determinants and improve the health of children in Cumbria is necessary. The effective integration of services for safeguarding children and young people and promoting the mental health and wellbeing of children looked after is of significant importance.

- **Promote mental and emotional wellbeing.** Improving the mental health and wellbeing of young people is crucial to their long term life prospects. The provision of organised activities during the school holidays that provide a positive purpose and engage young people is essential.
## Mental Health in Numbers

<table>
<thead>
<tr>
<th>Description</th>
<th>National</th>
<th>Trend</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>The rate of admissions for intentional self harm in Cumbria is 234.5 per 100,000 of the population. Barrow has over three times the rate of admissions than Eden, at 330.9 compared to 110.3.</td>
<td>N/Av</td>
<td></td>
<td>NWPHO, Health Profiles, 2009-2010</td>
</tr>
<tr>
<td>42% of people in Cumbria claiming Incapacity Benefit or Severe Disablement Allowance do so for a mental or behavioural disorder.</td>
<td></td>
<td></td>
<td>NOMIS, May 2011</td>
</tr>
<tr>
<td>Cumbria has a higher rate of suicide and injuries undetermined than the national average at 9.1 per 100,000 people compared to 7.9 for England. Allerdale has the highest rate in the county at 12.4.</td>
<td></td>
<td></td>
<td>NHS, Information Centre 2008-2010</td>
</tr>
<tr>
<td>54,184 patients (12.9%) are on the depression register.</td>
<td>N/Av</td>
<td></td>
<td>NHS, Information Centre 2010-2011</td>
</tr>
<tr>
<td>In 2010, 37 men and 10 women died from suicide or injuries undetermined.</td>
<td></td>
<td></td>
<td>NHS, Information Centre 2010</td>
</tr>
<tr>
<td>There were 22.6 emergency hospital admissions for Schizophrenia per 100,000 people during 2009/2010.</td>
<td></td>
<td></td>
<td>NHS, Information Centre 2009-2010</td>
</tr>
<tr>
<td>88% of patients with diabetes and / or coronary heart disease in Cumbria have been screened for depression.</td>
<td>N/Av</td>
<td></td>
<td>NHS, Information Centre 2010-2011</td>
</tr>
<tr>
<td>The rate of emergency hospital admissions for mental health conditions is below that nationally at 200.8 per 100,000 people compared to 217 for England.</td>
<td>N/Av</td>
<td></td>
<td>Community Mental Health Profile, NEPHO, 2008/09-2010/11</td>
</tr>
<tr>
<td>On average, £186 per person is spent on mental health services in Cumbria.</td>
<td></td>
<td></td>
<td>Community Mental Health Profile, NEPHO, 2011-2012</td>
</tr>
<tr>
<td>12,204 adults in Cumbria had contact with secondary mental health services during 2010-2011, of which 841 were admitted for care.</td>
<td></td>
<td></td>
<td>Mental Health Minimum Dataset, 2010-2011</td>
</tr>
<tr>
<td>130.4 bed days were used for mental health during 2010/11 per 1000 people.</td>
<td>N/Av</td>
<td></td>
<td>Community Mental Health Profile, NEPHO, 2011-2012</td>
</tr>
<tr>
<td>There were 107,776 face to face contacts with Community Psychiatric Nurses during 2010/11.</td>
<td></td>
<td></td>
<td>Mental Health Minimum Dataset, 2010-2011</td>
</tr>
<tr>
<td>On average 78% of all adults aged 18-64 years receiving secondary mental health services during live in settled accommodation.</td>
<td>N/Av</td>
<td></td>
<td>Health and Social Care, Mental Health Minimum Dataset, 2009-2010</td>
</tr>
<tr>
<td>Of all adults in Cumbria aged 18-64 years receiving secondary mental health services, on average 10% are known to be in employment.</td>
<td>N/Av</td>
<td></td>
<td>Health and Social Care, Mental Health Minimum Dataset, 2009-2010</td>
</tr>
</tbody>
</table>

**Key:**
- Red: Worse than
- Orange: Similar to
- Green: Better than
This section of the JSNA explores wellbeing and mental health in Cumbria. In this chapter, we focus primarily on people of working age. It is important that commissioners understand the link between wellbeing and good mental health on physical health, and the predicted rise in the number of people who will suffer from mental illness due to our ageing population.

Wellbeing and mental health are important assets at all ages.

Mental ill health can have far reaching impacts across generations. Poor parental mental health and difficulties parenting can increase the risk of mental health problems in children. At the other end of the life course the prevalence of dementia is predicted to increase from about 7,000 to about 13,000 in 2030, numbers of over 65s with depression are predicted to increase by about 5,000-7,000, and numbers of over 65s with a learning disability are predicted to increase by about 1,500.

Total costs of mental illness for England are estimated at £105.2 billion – or about £1 billion for Cumbria alone. Total (NHS and local authority) expenditure on adult and older adult mental health services in Cumbria in 2010/11 was almost £106 million.

The policy context

England’s Mental Health Outcome Strategy ‘No Health without Mental Health’, February 2012, highlights the link between good mental and physical health. Cumbria launched its own Strategic Framework, ‘Working Together for Wellbeing and Mental Health’ in October 2011. Its twin objectives are that more people have good mental health and wellbeing, and more people recover sooner from mental health problems.

It also seeks to:

- provide a focus on priorities and outcomes for mental health and wellbeing during the crucial transition period 2011-2014.
- promote wellbeing and early intervention to prevent mental health problems
- champion the integration of mental health into primary care to address people’s mental and physical health needs together
- ensure high quality, recovery focused specialist services are available to all when needed
- empower citizens, service users and carers and improve their experience of care.

Other local plans to inform commissioning decisions for mental health include:

- The Cumbria Health and Wellbeing Strategy
- The Cumbria Suicide Prevention Strategy.
### Figure 17: Mental Health and Wellbeing

#### Districts compared to Cumbria

<table>
<thead>
<tr>
<th>Metric</th>
<th>Allerdale</th>
<th>Barrow</th>
<th>Carlisle</th>
<th>Copeland</th>
<th>Eden</th>
<th>South Lakeland</th>
</tr>
</thead>
<tbody>
<tr>
<td>1% All benefits claimants</td>
<td>14.9%</td>
<td>21.8%</td>
<td>16.9%</td>
<td>17.8%</td>
<td>9.2%</td>
<td>8.9%</td>
</tr>
<tr>
<td>2% who feel they belong to their immediate neighbourhood</td>
<td>76%</td>
<td>67%</td>
<td>63%</td>
<td>67%</td>
<td>77%</td>
<td>73%</td>
</tr>
<tr>
<td>3% of physically active adults</td>
<td>14.2%</td>
<td>15%</td>
<td>14%</td>
<td>16.7%</td>
<td>17.1%</td>
<td>14.3%</td>
</tr>
<tr>
<td>4 Hospital admissions for neuroses</td>
<td>15.8</td>
<td>29.6</td>
<td>19.8</td>
<td>15.5</td>
<td>19.1</td>
<td>15.4</td>
</tr>
<tr>
<td>5 Hospital admissions for deliberate self-harm</td>
<td>175.9</td>
<td>330.6</td>
<td>309.7</td>
<td>259</td>
<td>110.3</td>
<td>176</td>
</tr>
<tr>
<td>6 Mortality from suicide and injuries undetermined per 100,000.</td>
<td>12.4</td>
<td>5.8</td>
<td>10.5</td>
<td>8.2</td>
<td>8.7</td>
<td>7.4</td>
</tr>
</tbody>
</table>

#### Cumbria Trend and Comparison

<table>
<thead>
<tr>
<th>Metric</th>
<th>Cumbria</th>
<th>Trend</th>
<th>Compared to North West</th>
<th>Compared to England</th>
</tr>
</thead>
<tbody>
<tr>
<td>1% All benefits claimants</td>
<td>13.8%</td>
<td>Similar to</td>
<td>18%</td>
<td>14.4</td>
</tr>
<tr>
<td>2% who feel they belong to their immediate neighbourhood</td>
<td>70%</td>
<td>Similar to</td>
<td>No data</td>
<td>59%</td>
</tr>
<tr>
<td>3% of physically active adults</td>
<td>14.7%</td>
<td>Similar to</td>
<td>11.2%</td>
<td>11.7%</td>
</tr>
<tr>
<td>4 Hospital admissions for neuroses</td>
<td>18.8</td>
<td>Deteriorating</td>
<td>30.1</td>
<td>16.4</td>
</tr>
<tr>
<td>5 Hospital admissions for deliberate self-harm</td>
<td>234.5</td>
<td>No data</td>
<td>263.2</td>
<td>198.3</td>
</tr>
<tr>
<td>6 Mortality from suicide and injuries undetermined per 100,000.</td>
<td>9.1</td>
<td>Improving</td>
<td>9.1</td>
<td>7.9</td>
</tr>
</tbody>
</table>

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

In 2009, Cumbria took part in the North West Wellbeing Survey, which for the first time established a baseline for mental wellbeing rather than mental illness. Cumbria’s mean score of 26.7 was below the North West average of 27.7 out of a maximum possible score of 35.

Only South Lakeland scored above the regional average and Eden had the worst score. The key factor associated with poorer than expected wellbeing in Eden appeared to be financial uncertainty, see Figure 18.

The survey also showed that people with high levels of wellbeing are much more likely to be able to make sustainable lifestyle changes, be in good health, manage and recover from illness sooner and use health services better, be satisfied with where they live, be in employment, and have few money worries than people with lower levels of wellbeing.

By underpinning how we think, feel and function, high levels of mental wellbeing can also lead to improvements in employment and productivity, educational attainment, life expectancy, community safety and cohesion.
Patterns of mental illness in Cumbria

Poor mental health affects about one in six adults at any one time and one in four people in their lifetime. This means that up to 75,000 Cumbrians may experience mental health problems, of whom about 10,000 may develop severe mental illness and need significant support to recover.

Mental illness often begins early. Around one in 10 children aged 5 to 16 have a diagnosable mental disorder – about 10,000 children and young people in Cumbria - and 50% of people with lifetime mental illness present by the age of 14.

Mental illness accounts for a fifth of the total burden of disease in the UK, higher that either cardiovascular diseases (16.2%) or cancer (15.6%). Moreover, mental and physical illness often coexists, with depression noted in 13-57% of cancers and 30-50% of heart attacks. Co-morbidity can result in suboptimal treatment of both conditions.

Figure 19: % Practice population aged 18+ diagnosed with depression

Across Cumbria, 54,184 of the practice population aged 18 and over (12.9%) has been diagnosed with depression (see Figure 19 for district breakdown), compared to 12.8% across the North West and 11.2% across England. A smaller number of people are diagnosed with schizophrenia, bipolar disorder and other psychoses: 4,353 (0.8%) across Cumbria, compared to 64,734 (0.9%) across the North West and 437,914 (0.8%) for England.

It appears that there are higher than expected numbers of people recorded with a diagnosis of depression in the more affluent district of Eden and fewer than expected in the more socially disadvantaged districts of Allerdale, Copeland, Carlisle, and Barrow, where the actual, but unrecorded, prevalence is likely to be higher.
07 Challenge 3 – Mental Health and Wellbeing

**Risk Factors**

Certain factors may increase the risk of developing mental health problems, including:

**Poverty and the economic downturn**

Cumbrians experiencing deprivation are more likely to experience mental health problems. Around 87,000 people in Cumbria live in deprivation; see Figure 5 (map of deprivation).

Cumbria, like other parts of the global economy, is also being affected by the economic downturn. There were 9,615 Job Seeker Allowance (JSA) claimants in Cumbria in January 2012, a rise of 1,248 (14.9%) over the year, the highest number since July 1999. Nearly a third of all claimants (3,165) were aged 16-64. However Cumbria’s JSA rate of 3.1% is less than the North West average of 4.6% and the UK average of 4.1%. Rates are highest in Barrow-in-Furness (4.4%) and Copeland (3.9%), see Figure 17.

**Figure 20: % of the population aged 16+ claiming incapacity benefit or severe disablement allowance**

Source: NOMIS, Feb 2012

High numbers of Cumbrians are out of work because of mental ill health, especially in more deprived urban areas. As Figure 20 below shows, rates of benefit claimants both for any condition and for mental health and behavioural conditions are particularly high in Barrow-in-Furness, and are also higher than the national average in Allerdale, Carlisle and Copeland.
Health inequalities

As with many other conditions, we know that mental health and illness is closely associated with inequalities and social disadvantage (see Challenge 1). It is estimated that 35% of people with mental illness live in the fifth most deprived areas of the Cumbria.

Mental illness is a major contributor to inequalities in health outcomes. On average, people with schizophrenia die 25 years younger than the general population. The contribution of depression to increased mortality is equivalent to the effect of smoking.

Long Term conditions

People with long term conditions often suffer from depression and anxiety, and many experience significantly poorer health outcomes and reduced quality of life as a result. GP Quality and Outcomes Framework (QOF) mental health indicators help measure whether people with chronic conditions are being screened for depression. Screening allows patients to be offered the mental health support they need.

For those with Coronary Heart Disease and/or diabetes, 88% have been screened for depression in Cumbria. This is similar to the national average of 89%.

Self harm

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

• A survey of young people aged 15–16 years estimated that more than 10% of girls and more than 3% of boys had self harmed in the previous year. In contrast to suicide, where 75% of deaths occur in males, self harm is more prevalent in females.
• Across Cumbria, there were 1,592 accident and emergency department attendances for self harm in 2010/11 of which 56% were female. The highest rates of self harm attendances occurred in females aged 10 to 19 and in males aged 20 to 29.
• Hospital stays for self harm are significantly higher than the national average at 235 per 1000 compared to 198 nationally.

Drug and alcohol misuse

There is a correlation between drug and alcohol misuse and mental health problems. See Figure 4 for drug and alcohol misuse prevalence in Cumbria.
Learning disabilities

The estimated 9,400 adults with a learning disability in Cumbria are at a higher risk of experiencing mental health problems and are likely to have a lower health literacy, meaning that interventions may be less effective. By 2030 the number of people in the county with learning difficulties is projected to rise by 731, putting a further demand on services.

People with learning disabilities experience amongst the lowest levels of employment of any working age group. The aim is to increase the numbers of people with a Learning Disability who are self-employed and/or in employment.

A national survey identified that people with learning disabilities may be at increased risk of hate crime; there is little understanding of this in the general population and within community safety initiatives.

Improving wellbeing in Cumbria

Localities across Cumbria are developing more and better community services, alongside preventative models of care. ‘Social prescribing’ is being piloted in several parts of Cumbria. This is a mechanism for linking people in primary care with non-medical resources in the community to strengthen their wellbeing. This can be through increasing skills, increasing sources of social support, and increasing access to resources and services that protect wellbeing such as arts and creativity, physical activity, volunteering, mutual aid, befriending and self-help, as well as support with employment, benefits, housing, debt, legal advice, or parenting problems.

Cumbria has also signed up to a regional Decade of Wellbeing initiative. This encourages people to work collectively to create a healthier Cumbria and to build Five Ways to Wellbeing into their daily routines, thus potentially adding 7.5 years to their life expectancy.

The 5 ways to wellbeing are:

Connect... with the people around you.
Be active... Go for a walk or run.
Take notice... Be curious.
Keep learning... Try something new.
Give... Do something nice for a friend, or a stranger.

Mental Health in Primary Care

GPs are the first point of contact for most people who experience health problems.

The role of primary care in the management of common mental disorders, and in making linkages between physical and mental health, is especially important. In recent years, mental health has been integrated into primary care to enhance access, enable earlier diagnosis, decrease stigma, improve outcomes and reduce costs. Primary care workers are uniquely placed to understand and address people’s needs holistically, and to collaboratively manage their patients care in partnership with the patient, other providers of health services and non-health services and interventions.
Mental Health Services

Cumbria Partnership NHS Foundation Trust is the main provider of mental health care services for adults and children and young people across Cumbria. The Trust also provides learning disability, condition management services and acquired brain injury services and, since April 2011, community health services.

Responding to the national policy agenda and to local needs, significant recent service developments include:

- rationalization of inpatient beds;
- repatriation of 10% of out of area placements;
- commissioning of a mental health liaison service to better address the needs of people with mental health problems in acute hospitals;
- restructuring of community mental health services;
- development of an eating disorder service;
- review of services for people with personality disorder;
- development of the First Step service.

Total numbers of people in contact with mental health services in Cumbria have increased steadily in recent years, while numbers admitted to hospital during the year have decreased (Mental Health Minimum Dataset, MHMDS), see Figure 21. This may in part reflect development of intervention services such as First Step. Better care in the community is also helping to avoid unnecessary and costly hospital admissions.

Figure 21: Cumbria Partnership Foundation Trust number of people using Mental Health services - between 2008-09 and 2010-11
First Step

First Step is Cumbria’s Improving Access to Psychological Therapies service, delivered by Cumbria Partnership NHS Foundation Trust. Currently over a thousand people a month with mild to moderate mental health problems such as anxiety and depression are referred or self refer to First Step. The service has amongst the highest recovery rates and highest access rates of all Improving Access to Psychological Therapies services in the North West. The service focuses on providing people with easy and timely access to evidence based therapies which are in keeping with NICE guidelines to provide support for a range of disorders such as sleep problems, depression or anxiety disorders such as chronic worry, panic attacks, obsessions or support following a traumatic incident.

Social care services

Cumbria is committed to a social model of mental health. This means addressing people’s health, social and material needs holistically. Cumbria County Council commissions and provides vital support to people with mental health problems and their carers, subject to assessment of need.

Services include:
• information and advice;
• day care and home care;
• help with housing, social problems, and employment.

In line with the rest of the Council’s social care services, personalisation is being introduced to mental health. This is to allow people in receipt of social care support to use personal budgets to direct the funding available to them to meet their own needs in the way that suits them best. Cumbria County Council is also introducing new prevention models and has allocated £1 million for one-off grant funding to deliver innovative preventative schemes in 2012-14.

The Third Sector

Of the estimated 5,000 third sector organisations in Cumbria, around 30 provide a vital role in providing services to people recovering from mental health problems. Services provided range from Information, Advice and Advocacy to Residential Care and Crisis Services.

Third sector organisations are also well placed to support asset based approaches to supporting wellbeing and mental health. However their geographic distribution should be taken into account if existing inequalities in health and wealth are to be redressed. For example, a 2009 survey found only 5% of the county’s registered charities were based in Barrow, where 15% of the population live, while 32% of the registered charities were based in South Lakeland, where 22% of the population live.

A healthy workplace

Work is good for our long-term health and family wellbeing and is an essential part of a happy and fulfilling life. To support a healthy workplace, an Employers Bridge project has been set up to provide a central information point for employers on support around mental health issues in the workplace. Employers Bridge runs regular events on themes such as ‘Recognising mental ill health in the workplace’, ‘How to support employees’, and ‘Understanding employment law and legislation’.
### Suicide and suicide prevention

The worst possible outcome for people suffering from mental illness is suicide. On average over the past 15 years, 57 people have died through suicide each year in Cumbria. About 10-15 more people die through suicide in Cumbria than would be expected if Cumbria had the same rates as the rest of England.

Although deaths through suicide represent only 1% of all deaths in Cumbria, they account for about 6% of years of life lost to premature death. Suicide rates are highest in younger people, especially young men and higher amongst people living in more deprived areas. However there are some indications that the Cumbria suicide rate may be decreasing, see Figure 22.

**Figure 22: Death from suicide and injury of undetermined intent excluding “verdict pending” in Cumbria. 3 years rolling averages 1993/4/5/ to 2008/9/10 and target for the year 2010**

Since January 2009 Cumbria’s Suicide Prevention Reference Group has taken forward action to prevent suicides, as outlined in the Cumbria Suicide Prevention Strategy and Action Plan.

Achievements to date include:
- Monitoring of media reporting of mental health and suicide
- Development of a screening tool to identify people at high risk of suicide
- Production of a care pathway to manage suicidal people
- Production of annual epidemiological reviews of suicide
- Launch of a local peer led branch of ‘Survivors of Bereavement by Suicide’.

One of the first tasks of Cumbria’s suicide prevention group was to gain insights from mental health service users and carers. Family members were able to explain how their experience of bereavement was like no other. One person’s remark summed it up: “I wish we could talk about it more”. Volunteers agreed to organise a support group for people bereaved through suicide with the help of the national charity ‘Survivors of Bereavement through Suicide’ (SOBs). As well as meeting regularly, members have become active advocates for suicide prevention.
Cumbria has a rapidly ageing population. Over the last century life expectancy has risen – this is a great achievement, but there are large differences in life expectancy and health indicators across the county. There are more people aged over 85 than ever before; this will have significant implications for health and social care services in the future. This chapter explores some of the challenges that an ageing population will bring, and some projections for the future.

Views of local people

Community development and regeneration initiatives can impact positively on mental health, therefore Asset Based Community Development is being actively promoted across Cumbria as a key vehicle to strengthen communities, deliver improved health and wellbeing and gather the views of local people.

Cumbria Mental Health Group, alongside other third sector organisations, helps people to navigate the complexities of mental health support services and to give them a voice. Feedback from users and carers shows:

- Insufficient focus on prevention, awareness raising, education and training
- Insufficient ‘marrying up’ of services for mental health
- Some specialist services and staff are overstretched
- Some services are not sufficiently user focused
- Perceived difficulties accessing support in time of crisis
- Perceived difficulties related to transitions from young people’s to adult services and from adult to older adult services
- A perceived lack of open access to high quality recovery focused support
- A perceived lack of support for people bereaved through suicide
- The specific needs of some hard to reach communities are not fully met, including gypsies and travellers and gay and lesbian people.

Key considerations for commissioners

Policy makers and commissioners need to ensure that all key strategies and programmes positively affect wellbeing and mental health.

In the coming year, whole systems reviews will focus on areas of concern, in particular: the quality and capacity of the Child and Adolescent Mental Health Services (CAMHS); the rehabilitation and recovery pathway; and the effective use of Psychiatric Intensive Care. Ongoing challenges include the development of an integrated service across health, social care and the third sector that will support the development of a more sustainable community based offer.

When planning mental health services, the key points for commissioners and service planners to consider are:

- **Good mental health is more than just the absence of mental illness.** Screening programmes, such as the NHS Health Checks programme, offer an ideal opportunity to emphasise wellbeing and the need for self management. All public sector staff should be encouraged to make “Every Contact Count” by providing information about the ‘Five Ways to Wellbeing’ – connect, be active, take notice, keep learning and give – and help people build them into their everyday lives.

- **Mental health and physical health problems often coexist.** Health and wellbeing would be improved by increasing access to psychological therapies for people with physical health problems; improving pathways for people with a ‘dual diagnosis’ of mental illness and drug and alcohol problems; and ensuring that people with learning disabilities have access to appropriate information related to their health.

- **Improve services and contain mental health related costs.** The impact of investment in mental health prevention and continued work to develop mental health services within Cumbria to avoid costly out of county placements and to reduce hospital admissions for mental health should improve outcomes and show a cost benefit.
### Ageing Population in Numbers

<table>
<thead>
<tr>
<th>Description</th>
<th>National</th>
<th>Trend</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>By 2035 the population of Cumbria aged over 65+ years is due to increase by 60.5% and make up around a third of the county’s population.</td>
<td></td>
<td></td>
<td>2010 ONS Sub National Population Projections</td>
</tr>
<tr>
<td>In 2009/2010 75% of people aged over 65 years were vaccinated against influenza.</td>
<td></td>
<td></td>
<td>NHS Information Centre, 2009-2010</td>
</tr>
<tr>
<td>At age 65 years a man in Cumbria can expect to live for an additional 18.1 years and a woman for an additional 20.1 years.</td>
<td></td>
<td></td>
<td>NHS Information Centre, 2008-2010</td>
</tr>
<tr>
<td>The rate of emergency hospital admissions for hip fractures among the 65+ age group in Cumbria is similar to that at a national level at 455 admissions per 100,000 of the population.</td>
<td></td>
<td></td>
<td>NWPHO, Health Profiles, 2009-2010</td>
</tr>
<tr>
<td>It is estimated that 508 men and 1217 women aged over 65 were admitted to hospital for serious accidental injury in 2008/2009.</td>
<td></td>
<td></td>
<td>NHS Information Centre, 2008-2009</td>
</tr>
<tr>
<td>23% of deaths occur at home.</td>
<td></td>
<td></td>
<td>NHS Information Centre, 2008-2010</td>
</tr>
<tr>
<td>825 people underwent a primary hip replacement during 2009/2010.</td>
<td></td>
<td></td>
<td>NHS Information Centre, 2009-2010</td>
</tr>
<tr>
<td>21,300 pensioners are claiming pension credit to top up their income.</td>
<td></td>
<td></td>
<td>NOMIS, August 2011</td>
</tr>
</tbody>
</table>
Ageing population

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

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

With an ageing population, dementia is likely to be a significant issue across the county as well as increasing levels of long term illness and sensory impairment. Additionally, those with existing physical and learning disabilities are living longer, increasing the need for more complex packages of support.

Figure 23: Change overtime of the proportion of the population aged 65 and over comapring District with Cumbria and England. Source: ONS 2010-based projections
The assets within an ageing population

It is important to remember the wealth of assets within an ageing population. Many older are making a valuable contribution to the economy by working longer, or as carers or volunteers. The contribution that carers make to the economy is estimated to be worth twice that of public spending on care.

In 2009 Cumbria Council for Voluntary Service undertook a survey of registered charities to explore the impact of volunteering on the economy and communities of Cumbria and found that:

- 50,000 volunteers support registered charities in the county
- Volunteers provide 45,750 hours of volunteering per week
- These volunteer hours equate to an additional 1,220 full time staff
- Volunteers contribute an additional financial value of £28.5 million per year to registered charities.

The policy context

The challenge posed to health and social care services at a national level by the ageing population is acknowledged in the Adult Social Care Outcomes Framework, the NHS Outcomes Framework, and the Public Health Outcomes Framework and was identified as a key challenge in the Cumbria JSNA of 2009.

Local plans to inform commissioning decisions for older people include:

- Growing Older in Cumbria
- Implementing the National Dementia Strategy - Working together to Improve Life with Dementia in Cumbria – NHS Cumbria and Cumbria County Council
- The Joint Commissioning Strategy for End of Life Care for Adults in Cumbria - NHS and Cumbria County Council
- Cumbria Commissioning Strategy for Older people and their Carers 2010-2019 – Cumbria County Council
## 08 Challenge 4 – Ageing Population

### Cumbria Trend Compared to North West Compared to England

<table>
<thead>
<tr>
<th>Metric</th>
<th>Allerdale</th>
<th>Barrow</th>
<th>Carlisle</th>
<th>Copeland</th>
<th>Eden</th>
<th>South Lakeland</th>
<th>Cumbria</th>
<th>Trend</th>
<th>Compared to North West</th>
<th>Compared to England</th>
</tr>
</thead>
<tbody>
<tr>
<td>1% of people aged 65+</td>
<td>20.4%</td>
<td>18.6%</td>
<td>18.6%</td>
<td>18.9%</td>
<td>21.4%</td>
<td>23.7%</td>
<td>20.4%</td>
<td>Deteriorating</td>
<td>N/Av</td>
<td>16.5%</td>
</tr>
<tr>
<td>Indices of Multiple Deprivation Affecting Older People IMD 2010</td>
<td>0.18</td>
<td>0.21</td>
<td>0.17</td>
<td>0.17</td>
<td>0.11</td>
<td>0.11</td>
<td>0.16</td>
<td>Similar to</td>
<td>N/Av</td>
<td>0.21</td>
</tr>
<tr>
<td>Hypertension: QOF prevalence (all ages)</td>
<td>15.5%</td>
<td>15.1%</td>
<td>14.3%</td>
<td>16.2%</td>
<td>15.6%</td>
<td>15.8%</td>
<td>15.0%</td>
<td>Similar to</td>
<td>N/Av</td>
<td>13.4%</td>
</tr>
<tr>
<td>Stroke: QOF prevalence (all ages)</td>
<td>2.40%</td>
<td>2.00%</td>
<td>2.10%</td>
<td>2.10%</td>
<td>2.20%</td>
<td>2.70%</td>
<td>2.30%</td>
<td>Similar to</td>
<td>N/Av</td>
<td>1.70%</td>
</tr>
<tr>
<td>Heart failure: QOF prevalence (all ages)</td>
<td>1.10%</td>
<td>0.90%</td>
<td>1.10%</td>
<td>1.00%</td>
<td>0.80%</td>
<td>1.20%</td>
<td>1.00%</td>
<td>Similar to</td>
<td>N/Av</td>
<td>0.70%</td>
</tr>
<tr>
<td>Cancer: QOF prevalence (all ages)</td>
<td>0.60%</td>
<td>0.80%</td>
<td>0.70%</td>
<td>0.60%</td>
<td>0.60%</td>
<td>0.80%</td>
<td>0.70%</td>
<td>Similar to</td>
<td>N/Av</td>
<td>0.50%</td>
</tr>
<tr>
<td>Non-elective admissions aged 65+ per 1000 pop 65+</td>
<td>196</td>
<td>237</td>
<td>210</td>
<td>219</td>
<td>176</td>
<td>187</td>
<td>196</td>
<td>Similar to</td>
<td>254</td>
<td>N/Av</td>
</tr>
<tr>
<td>Non-elective bed days aged 65+ per head of 1000 pop 65+</td>
<td>1,633</td>
<td>2,671</td>
<td>2,173</td>
<td>1,937</td>
<td>1,584</td>
<td>1,948</td>
<td>1,885</td>
<td>Deteriorating</td>
<td>2337</td>
<td>N/Av</td>
</tr>
<tr>
<td>Non-elective re-admission rate within 28 days aged 65+</td>
<td>13.3%</td>
<td>13.1%</td>
<td>14.0%</td>
<td>14.0%</td>
<td>12.4%</td>
<td>12.9%</td>
<td>13.3%</td>
<td>Similar to</td>
<td>16.1%</td>
<td>N/Av</td>
</tr>
<tr>
<td>Non-elective Re-admission rate within 90 days aged 65+</td>
<td>23.0%</td>
<td>22.7%</td>
<td>24.6%</td>
<td>24.4%</td>
<td>21.6%</td>
<td>22.3%</td>
<td>23.2%</td>
<td>Similar to</td>
<td>25.9%</td>
<td>N/Av</td>
</tr>
<tr>
<td>Proportion of people aged 65+ discharged direct to residential care</td>
<td>2.7%</td>
<td>1.7%</td>
<td>2.1%</td>
<td>2.0%</td>
<td>1.3%</td>
<td>1.6%</td>
<td>1.9%</td>
<td>Similar to</td>
<td>2.3%</td>
<td>N/Av</td>
</tr>
</tbody>
</table>

**Key:**
- **Worse than**
- **Similar to**
- **Better than**
**The health and social care implications of ageing**

The health challenges of older people are different to those of working age adults. Growing older inevitably means that health declines and we are more likely to develop long term conditions such as heart disease and diabetes. Around 2000 people aged 65 and over are diagnosed each year with cancer.

Poor diet, malnutrition, physical inactivity and isolation are high in the elderly. With an ageing population we are set to see an increase in the prevalence of dementia, circulatory disease, falls and poor mental wellbeing, all of which will have an impact on health and social care services. The challenge is for as many people as possible to enjoy a good quality of life for as many years as possible.

**Long term conditions**

In 2011, there were 42,333 people in Cumbria aged over 65+ with a long term illness which limited their ability to undertake routine daily tasks. This number is estimated to increase by 61% by 2030 to 68,234. (Projecting Older People Population Information (POPPI)). Despite many medical advances there is still no cure for long term conditions, but leading a healthy lifestyle will delay the onset and reduce the prevalence of many of these illnesses. It is also increasingly important to support people to manage their own conditions.

<table>
<thead>
<tr>
<th>Condition</th>
<th>2011 (no)</th>
<th>2030 (no)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obese (BMI of 30 or over)</td>
<td>27,162</td>
<td>39,332</td>
</tr>
<tr>
<td>Bronchitis/emphysema</td>
<td>1,751</td>
<td>2,677</td>
</tr>
<tr>
<td>Dementia</td>
<td>7,271</td>
<td>13,106</td>
</tr>
<tr>
<td>Depression</td>
<td>8,970</td>
<td>13,520</td>
</tr>
<tr>
<td>Diabetes</td>
<td>12,920</td>
<td>19,540</td>
</tr>
<tr>
<td>Heart attack</td>
<td>5,092</td>
<td>7,816</td>
</tr>
<tr>
<td>Limiting long term illness</td>
<td>48,618</td>
<td>75,230</td>
</tr>
<tr>
<td>Moderate or severe hearing impairment</td>
<td>43,890</td>
<td>72,528</td>
</tr>
<tr>
<td>Moderate or severe visual impairment</td>
<td>9,116</td>
<td>14,498</td>
</tr>
<tr>
<td>Stroke</td>
<td>2,392</td>
<td>3,763</td>
</tr>
</tbody>
</table>

Source: POPPI

Commissioners need to understand which groups are affected by these conditions and the predicted increase in the number of people requiring services that will result from our ageing population.

About two-thirds of medicines prescribed are for people with long term conditions. In Cumbria in 2010, cardiovascular drugs accounted for 3,377,641 prescription items at a cost of £15,663,688. Drugs for diabetes accounted for 368,193 prescription items at a cost of £6,332,524. Studies report that 30-50% patients with long term conditions do not take prescribed medicines as intended.

NHS Cumbria and Cumbria County Council are currently working with voluntary organisations to develop and implement a fully integrated long term conditions model that will:

- Increase public awareness of the signs and symptoms of long term conditions
- Improve early detection and diagnostics in primary and secondary care
- Roll out agreed long term conditions pathways across all service delivery areas
- Develop and promote patient education programme to support optimal self care
- Shift the focus of care for clinical teams from disease based to co-ordination of care for an individual regardless of how many or which long term conditions they may be living with
- Use telecare and telehealth to improve quality of and access to care.

Levels of disability in the county are rising but remain similar to national levels. 20.6% of the working age population in Cumbria has a disability compared to 20.5% in England. Levels of disability are highest in Barrow in Furness at 25% and lowest in Carlisle at 15.7%.
Dementia

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

At present only around 45% of those with dementia in Cumbria are identified on GP practice dementia registers. Whilst this is higher than the national average of 39%, work needs to be undertaken to improve detection and early diagnosis. Currently around 80% of people diagnosed with dementia have had a care review in the previous 15 months, which again is slightly better than the national average.

The implications of increasing numbers of people with dementia in Cumbria are significant. Building on the National Dementia Strategy, the following issues are a priority:

• Good quality early diagnosis and management for all
• Improved quality of care in hospitals and care homes
• Reduced use of anti-psychotic medication.

Increasing Hospital Admissions

As the over 65 population in Cumbria increases, the number of hospital admissions will also increase. During 2011 just over 40% (57,593 episodes) of hospital admissions in Cumbria were to people aged 65 and over. The most common condition for older people going to hospital during the year was cancer, accounting for 15% of the total (8,854 episodes.) Digestive disease was the second most common reason for admission (7,755 episodes). This was closely followed by circulatory diseases (7,418 episodes) see Figure 25.

Figure 25: Hospital admissions for people aged 65+ in 2011 - 40% of all hospital admissions

CHALLENGING THE MYTHS OF AN AGEING POPULATION

• 4 in 5 people over the age of 80 do not suffer from dementia.
• 60% of people aged 65 to 74 nationally have used the internet.
• 73% of people are living independently at the age of 97 and 35% are still independent at the age of 100.
• Just over half (52%) of people aged 70+ have a full car driving licence.
Preventing hospital admissions due to falls in older people is a key public health priority. This is due to the dramatic impact that falling can have upon older people's subsequent health and wellbeing, as well as the high economic costs arising from the health and social care interventions after a fall.

Over 30% of people aged over 65 and over 50% of people aged over 80 will suffer a fall. Around 20% of older adults will require medical attention for a fall, and around 5% will suffer a serious injury such as a fracture. In 2011, 611 people aged 65 and over suffered from a hip fracture. By targeting intervention at those at risk of falls, risk will be reduced for the individual, and costs for health and social care will reduce.

With more care being provided in the community, built around the needs of local people, Cumbria’s Closer to Home programme is working to support a reduction in unnecessary hospital admissions cross all ages and conditions.

Rehabilitation and Reablement Services in Cumbria

Health and social care colleagues now work much more closely together, taking a joined-up approach to assessing a patient’s support needs and helping those who would otherwise have ended up in a costly hospital bed to stay at home.

Social workers and nursing staff, including allied health professionals, nurses and therapy assistants, work as one team across each locality.

The service and support offered allows patients to maintain their independence and stay in their own home or promote an early return from hospital, allowing patients to continue their recovery in familiar surroundings. Patients are constantly monitored. The package of support is individual to each patient and can be quickly changed if needed. Support can last from a few days, to six weeks. In some cases support may be as simple as getting patients a special chair; in others they may need several visits a day from physiotherapists and carers. The majority of referrals come from GPs, social workers or hospital staff. Links are also made with independent organisations such as Age Concern to identify at-risk patients, for example those who may be at risk of falls, and looking at how this can be prevented.

Reablement is an Adult Social Care funded service which aims to help people regain their independence following an illness, injury, disability or loss of personal support network. Evidence tells us that we need to develop this service across the county- nationally we know that where reablement is in place typically 40% of people accessing the service do not need ongoing care. This important initiative will complement the work of specialist rehabilitation services in the county.
**Adult social care services**

There are 17,359 adult social care users in Cumbria, 74% of which are aged over 65 years. Among adult social care users aged 65 and over in 83% have a primary client type of physical disabilities.

There were variations in number across Cumbria’s districts, as shown in Figure 26.

Those receiving social care often face multiple health issues and require a variety of services, with the average adult social care user in Cumbria accessing over three different services.

The number of adults requiring health and social care services within Cumbria will increase as our population ages. The use of social care services across the county reflects both levels of social disadvantage and the age of local populations (see Figure 27).

**Figure 26: Adult Social Care service users by primary client type**

![Figure 26: Adult Social Care service users by primary client type](image)

Source: Adult Social Care, April 2010-March 2011
Those receiving social care often face multiple health issues and require a variety of services, with the average adult social care user in Cumbria accessing over three different services.

The number of adults requiring health and social care services within Cumbria will increase as our population ages. The use of social care services across the county reflects both levels of social disadvantage and the age of local populations (see Figure 27).

We know that we have a challenge to provide social care services which help people regain and maintain independence, offer a choice of provision and allow people to take control of their own care and support. Services of the future will need to develop to focus on assistive technologies, community equipment, reablement and other responsive community services, falls prevention and increased support for people with dementia.

**Figure 27: Map showing the rate of people aged 65 and over supported by adult social care services in the community per 1,000 population**

[Map showing the rate of people aged 65 and over supported by adult social care services in the community per 1,000 population]
Everyone is at risk of developing heart disease, stroke, type 2 diabetes or kidney disease, and the risks increase as we age. However, these diseases can often be prevented. NHS Health Check can help by assessing peoples risk and giving personalised advice on how to reduce it.

During 2011-12 NHS Cumbria piloted a vascular screening programme in Copeland and this has shown impressive results in detecting previously undiagnosed vascular conditions. Vascular disease affects more than four million people in the UK and is responsible for a fifth of all hospital admissions. Heart disease, stroke, diabetes and kidney disease are all types of vascular disease. All these diseases share a similar set of risk factors: smoking, obesity, physical inactivity, high blood pressure and raised cholesterol levels are all known to lead to a build-up of fatty deposits in the blood vessels. The intention is to roll out a county wide programme in 2012 as part of the NHS Health Checks programme. People aged over 40 who are found to be at increased risk of a vascular condition will be provided with advice and signposting to healthy lifestyle services plus clinical treatment for any prevailing medical conditions detected. Nationally, this could prevent 9,500 heart attacks and strokes every year and save 2,000 lives. The NHS Health Check is for adults between the ages of 40 and 74. It is being rolled out across Cumbria to help people take charge of their long-term health.

Disabled Facilities Grant Investment by district

<table>
<thead>
<tr>
<th>District Council</th>
<th>Spend 2011-12</th>
<th>Planned 2012-13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allerdale</td>
<td>£525,456</td>
<td>£600,000</td>
</tr>
<tr>
<td>Barrow</td>
<td>£557,751</td>
<td>£700,000</td>
</tr>
<tr>
<td>Carlisle</td>
<td>£1,020,486</td>
<td>£863,000</td>
</tr>
<tr>
<td>Copeland</td>
<td>£532,135</td>
<td>£500,000</td>
</tr>
<tr>
<td>Eden</td>
<td>£350,000</td>
<td>£250,000</td>
</tr>
<tr>
<td>South Lakes</td>
<td>£598,538</td>
<td>£645,000</td>
</tr>
<tr>
<td>TOTAL</td>
<td>£3,234,366</td>
<td>£3,558,000</td>
</tr>
</tbody>
</table>

DFG spend has been rising year on year, a fourfold increase in demand since 2006. It is expected to rise further as more people are supported to remain in their own home.

Many older people in Cumbria are owner-occupiers, who are often asset rich but income poor. The Government is working on equity release schemes to help owner-occupiers fund works to their home.

Older people have said that they want support to be independent and remain in their own home for as long as possible.

In 2011 there were 292 excess winter deaths (observed winter deaths minus expected deaths based on non winter deaths). The majority of these excess winter deaths are in people over 75 and many of these deaths are preventable. In particular, fuel poverty (where a household spends more than 10% of its income on fuel) is associated with excess winter deaths. Levels of fuel poverty in Cumbria are significantly higher than England, with the level of fuel poverty in the rural district of Eden over twice that of the national average.

Between 2006 and 2009 levels of fuel poverty in Cumbria have risen by 9% to reach 28%. Cumbria’s Affordable Warmth Project has developed a fuel poverty strategy and works in partnership with other agencies to access funding for insulation.

The District Councils are working with both Health and Social Care to ensure homes are adapted to make them suitable for residents. Disabled Facilities Grants are available to provide equipment such as stair lifts or level access showers. Currently those who receive help are means tested, however it is estimated nationally that only 1 in 10 of those who need help receive it. Health, housing and Social Care are working on a project to integrate the way we deliver adaptions to homes including the homes of our elderly population, disabled and those with learning disabilities.
Tackling social isolation

Often older people end up on living on their own in a home that is too big for them and difficult to maintain. In many rural areas this can lead to social isolation, especially when the person is no longer able to drive. Tackling social isolation in older people is a growing public health concern. Cumbria has taken part in a number of schemes to help to reduce social isolation in the elderly.

**Homeshare** provides housing in exchange for help in the home. A householder offers free or low-cost accommodation in exchange for an agreed level of support. Homeshare provides a solution to the needs of two groups of people - those in need of affordable housing, and those in need of support to live at home.

**Ageing Well Digital Exchange** is an intergenerational project which aims to get more older people connected to the internet using young people to help make this happen. Social isolation is reduced, savings made in household bills and better access to help, advice and information are all made possible.

A ‘**Centre for the Third Age**’ has been established at Cockermouth Community Hospital as a single place for older people to get advice and help. Health and social care professionals alongside community groups, agencies and charities have all worked together to support Cockermouth’s ageing population. The ‘Centre for the Third Age’ brings a whole range of organisations and groups together to support older people and create a community support network for both older people and carers across the area.

**The Cumbria Support Directory** is an online directory of services being introduced by Cumbria County Council’s Adult Social Care. The directory will include details about the full range of services and support available in Cumbria including: social care and support, health and wellbeing, housing, leisure, learning, employment, money matters, advice and information, transport, equipment and carers’ support. For an ageing population, improving access to public and voluntary services can support people’s health, wellbeing and social needs. The directory will help people to find out about the range of options open to them including some they may not have considered.
**Safeguarding adults**

Abuse and neglect of anyone is intolerable. ‘Safeguarding adults’ covers everything that assists a ‘vulnerable’ adult to live a life that is free from abuse and neglect and which enables them to retain independence, wellbeing, dignity and choice. Safeguarding is everyone’s responsibility. All staff who have contact, either directly or indirectly, with children, families and vulnerable adults, or who have access to information about them, have a responsibility to safeguard and promote their welfare.

In Cumbria there were more than 6,450 incidents of domestic violence were reported to the police in 2010.

**Support for Carers**

Carers are one of our greatest assets, and critical to helping people with support needs to live well.

There are approximately 51,700 people in Cumbria providing some form of care, with 16,500 providing 20 or more hours per week and 10,600 providing 50 or more hours per week. (2001 census).

In 2005, it was estimated that there were around 15,000 people over the age of 60 providing care in Cumbria, with the highest proportion in Barrow (15%) and the lowest in Eden (11.9%). The majority of older carers are providing care for a partner and this is particularly common for male carers over the age of 75 (Carers UK, 2005).

Carers can experience much poorer health than the rest of the population. 24.4% of full time carers in Barrow reported being in poor health, compared to 17.1% in Eden and South Lakes.

In Cumbria, 81.3% of carers reported being satisfied with the services and support that they received from social services whilst 7.4% reported some level of dissatisfaction. Accessing the services they need and communicating with service providers is a concern for many carers.

Cumbria has developed a carer’s strategy based on the core principles of the national strategy. It prioritises: information and access, finance, breaks for carers, emotional support, employment and learning, health and wellbeing, along with training for carers and those who work with them.

In the future, there will be a need for a greater number of carers to support our elderly population. This group need to be given the right support.

**Next generation care**

With many areas of care being managed from someone’s own home, our reliance on residential care homes is reducing. This is being supported by invested in a broad range of approaches including Telecare and re-enablement.

Next generation care will focus on:
- Investment in high level support for people to be supported at home
- Development of extra care housing
- Care homes that feature the latest design standards to support people with dementia.

As with hospital services, residential services should only be for those who require that high level of care.

In the future, residential services will continue to focus on specialist areas of care, such as dementia care.
End of Life Care

The ageing population of Cumbria will have an impact on end of life care services. The Joint Commissioning Strategy for End of Life Care for Adults in Cumbria sets out the framework within which good end of life care needs to be provided. The vision supports people with advanced or progressive incurable illness to live as well as possible until they die and to make decisions about their priorities for care and end of life.

- 64% of people in the North West identified home/usual place of residence as their preferred place to die.
- At 23%, the rate for deaths at home is higher than both the North West and England averages; however there is still a lot of room for improvement.
- Evidence suggests that at least 1% of the population is in their last year of life; however end of life registers only represent 0.17% of the population. This could mean that patients are not being identified as appropriate for the end of life care pathway and are not able to access appropriate levels of support for both themselves and their family/carers.

There is a need for well trained staff to support people with advanced progressive illness in the last six months to one year of their lives and through bereavement, including aspects of pain management, psychological, social, practical and spiritual support.

Seamless communication across all agencies is essential to ensure a sensitive approach to respecting a person’s care plan or Do Not Resuscitate status. The introduction of local shared records will allow this to be more joined up in the future.

Views of local people

To help shape services, improve quality of life and help older citizens to live life to the full, Cumbria County Council, Age UK and commissioner’s regularly seek the views of older people.

Older people have said that the following areas are important to them:
- Support to remain independent within their own homes
- Easy access to information on services
- Help and opportunities to remain active
- Services that are accessible, particularly in terms of travel time
- Improved integration between different health, social care and support services so that service users are not ‘bounced around’ the system
- Recognise the value of older people and ensure that high quality employment and volunteer opportunities are available to all.

Key considerations for commissioners

Our population is ageing and whilst the number of premature deaths from chronic disease is likely to decline in the future, the numbers of people living with long term conditions will increase considerably.

At the same time, there will be fewer people of working age to provide care.

The impact of demographic growth is not just on health and social care services. All Council services will need to review the ways in which their services need to adapt to meet different patterns of demand.

When planning services for our ageing population in Cumbria, the key points for commissioners and service planners to consider are:

- Increasing numbers of people will live to a greater
Key considerations for commissioners

Our population is ageing and whilst the number of premature deaths from chronic disease is likely to decline in the future, the numbers of people living with long term conditions will increase considerably.

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The impact of demographic growth is not just on health and social care services. All Council services will need to review the ways in which their services need to adapt to meet different patterns of demand.

When planning services for our ageing population in Cumbria, the key points for commissioners and service planners to consider are:

- **Increasing numbers of people will live to a greater age with a number of long term conditions.** Historically, investment in long term conditions has been on treatment and prevention of further deterioration, future investment should be focused on preventing or delaying the onset of long term conditions. People will need to be supported to self-manage their conditions through better patient education and enhanced care pathways, and the current middle aged population of Cumbria should be encouraged to take greater preventative action (e.g. stopping smoking and adopting healthier lifestyles) to promote healthy ageing and reduce the incidence of long term conditions.

- **Support communities to remain independent.** As people generally prefer to remain in their own homes as long as possible, developing services to enable them to do this will be particularly important. Developments in telecare, assistive technology, improved housing and personal budgets will be needed to support this, as well as preventative services to reduce risks from problems such as falls and a review into end of life care.

- **Many more will suffer from dementia.** Delivery of national and local dementia strategies in partnership with local authorities will be a key issue as the prevalence of dementia increases. Cumbria is going to see growing numbers of people with dementia in addition to other long term conditions. This will make management far more challenging.

- **Build capacity through partnership working.** An increasingly ageing population will create demand on health and social care service. Mobilising community assets and increasing joined-up working between the NHS, local authority, and voluntary sector will be needed, and further integration across health and social care will be a key issue across all care pathways.
Next Steps

We have the evidence to show what the key health and social care priorities are and this refresh of the JSNA will underpin our Health and Wellbeing Strategy to be developed in partnership as the next phase in our work to improve health outcomes for all, and particularly for the next generation.

Improving health and wellbeing and action on inequalities requires joint working across all partnerships. Our priorities include helping our service users and their carers enjoy an independent and safe life with maximum choice and we are committed to delivering services in the most effective and efficient way possible. In addition, we are committed to developing better outcomes for all children and adults in Cumbria, working with people in their natural communities rather than restricting ourselves to organisational boundaries.

Reduced Government funding will require innovative partnerships and more effective use of our assets. The role of the private and voluntary sector will also be one of the key drivers in achieving and sustaining change.

If health outcomes are to be improved, and inequalities tackled effectively in Cumbria and its localities, it is important that the JSNA and its evidence base continue to be reflected in multi agency joint planning processes.
10 Indicator Guide

Indicator Guide

Health Inequalities

1. % of adults aged 16-64 educated to NVQ4 or above, from the Annual Population Survey (APS), January 2010-December 2010.
2. % 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. % 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.
5. % 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.
6. Admission episodes for alcohol attributable conditions per 100,000 of the population, DSR, all ages, from Local Alcohol Profiles for England, 2009-2010.
9. 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.
10. Mortality from all cancers, DSR per 100,000 of the population, those aged under 75, from the NHS Information Centre, 2008-2010.
11. Mortality from all circulatory diseases, DSR per 100,000 of the population, those aged under 75, from the NHS Information Centre, 2008-2010.
13. Total gross income per household including earned and unearned (e.g. dividends, savings interest, pensions, benefits), CACI Paycheck 2011.
15. Total rate of crime and incidents per 1000 people, Cumbria Constabulary, 2010-2011.
17. % of the population aged 16-64 with a disability from the Annual Population Survey, June 2010-July 2011.
18. % of adults aged 16-64 with disabilities in employment from the Annual Population Survey, June 2010-July 2011.

Children and Young People

1. 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.
2. 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.
3. % of children attending state schools that belong to a school sports partnership that 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.
4. % of year 6 (aged 10-11) state school pupils classified as obese, from National Child Measurement Programme, 2010-2011 School year.
5. Rate of infant mortality under age one per 1000 live births, NHS Information Centre 2008-2010.
6. % of live and still births where the birth weight was less than 2,500 grams, NHS Information Centre 2010.
7. Conception rate per 1000 of the female population aged 15-17, ONS and Department for Education, 2008-2010.
10. NHS Cumbria Intelligence and Information team.
**Mental Health and Wellbeing**

1. % of the working age population (16-64) receiving state benefits, NOMIS, August 2011
2. Cumbria Place Survey Tracker, 2009.
3. % 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
4. 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
5. 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.
6. 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.

**Ageing Population**

1. Number of people aged 65 and over as a proportion whole population, Office for National Statistics, midyear estimates 2010
2. Proportion of adults aged 60+ living in income support, income based Job Seekers Allowance or pensions credit (guaranteed) families, Indices of Multiple Deprivation, 2010
3. % of patients with hypertension as recorded on practice disease register, Network of Public Health Observatories, National General Practice Profiles, 2011
4. % of patients with stroke or transient ischaemic attack as recorded on practice disease register, Network of Public Health Observatories, National General Practice Profiles, 2011
5. % of patients with heart failure as recorded on practice disease register, Network of Public Health Observatories, National General Practice Profiles, 2011
6. % of patients with dementia as recorded on practice disease register, Network of Public Health Observatories, National General Practice Profiles, 2011
7. % of patients with cancer as recorded on practice disease register, Network of Public Health Observatories, National General Practice Profiles, 2011
8. AQUA/ADASS North scorecard, extracted from the SUS Health system, 2011
9. AQUA/ADASS North scorecard, extracted from the SUS Health system, 2011
10. AQUA/ADASS North scorecard, extracted from the SUS Health system, 2011
11. AQUA/ADASS North scorecard, extracted from the SUS Health system, 2011
12. AQUA/ADASS North scorecard, extracted from the SUS Health system, 2011
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Cumbria

Joint Strategic Needs Assessment

2012-2015