Cumbria County Council

Cumbria Primary Care Trust NHS

Health in Cumbria 2008

The Annual Report of the Director of Public Health

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Introduction

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

The tradition of their independence was robustly defended and the Medical Officer of Health could not be sacked for drawing attention to unpalatable truth. In the maelstrom of local government reform in 1974, the post of Medical Officer of Health was abolished and the annual reports discontinued. However within a few years, public health scandals of a very traditional kind involving deaths from preventable infectious disease led in 1988 to an inquiry into the public health function in England and Wales and the reinstatement of these reports.

Since 1974, the arrangements for specialist public health expertise and intervention have been subject to the whim of ephemeral government. It was Caius Petronius who is first attributed with the observation that governments' response to most challenges is to reorganise and for the National Health Service and public health that is especially true. In my former role as Director of Public Health and Regional Medical Officer for the North West, I was heading into my fifth reorganisation in thirteen years when I decided you can have too much of a good thing.

This most recent reorganisation in 2006 has not only resulted in one health organisation for Cumbria – Cumbria Primary Care Trust – but has also given us the opportunity to re-establish those vital connections between the public health role in the NHS and the work of Cumbria County Council and the six Cumbrian District Councils, which is so vital in tackling the causes of ill health and in putting in place those arrangements to support people whose health has been damaged and enable them to lead as full a life as possible. The health and social system is much wider and deeper than the health service and social care system. The NHS cannot consume all societies' smoke and optimal health for all citizens can only be produced by partnerships at all levels.

Fortunately one door closed in the Government Office North West and another opened here in Cumbria: I find myself with an opportunity to work closely with a strong team both in the new Primary Care Trust, the County and District councils and the Cumbria Strategic Partnership and to reinvent joined-up public health in what has been described by Sir Derek Wanless as the 'Fully Engaged Scenario'. As Director

of Public Health and County Medical Officer, my team and I have the opportunity to work with and influence the whole health system and not just that of health care.

This first report on the health of all Cumbrians will provide a baseline assessment and a reference point for health improvement. It will describe the situation today and indicate where and how we need to act to secure the goal of equal access to a long and healthy life for all who live in this beautiful county. Reports like this are meaningless if they do not inform action. In future years this 2008 report will be a benchmark against which we can test how well we have done working together for this noble cause.

Photograph courtesy of Cumbrian Newspapers

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

Geography

The five largest towns in Cumbria:		
	Carlisle	68,300
	Barrow	59,600
	Kendal	25,500
	Whitehaven	24,900
	Workington	24,800

Our Medical Officers of Health

Prior to 1974, the area now known as Cumbria consisted of three unitary authorities; Westmorland, Cumberland and the Northern reaches of Lancashire. Each area or borough appointed their own Medical Officer of Health or MOH, to oversee and coordinate the Public Health role.

Throughout numerous local government district and county boundary changes, these are the men who made their contribution to community health from the late 19th Century onwards:

Cumbria can be a difficult county to travel round due to the limited road and rail access around our centrally located mountains and lakes.

For example:

Barrow to Carlisle:	85 miles, taking around 1 hour, 45 minutes by road
Workington to Penrith:	39 miles, taking 1 hour, 10 minutes by road
Whitehaven to Carlisle:	39 miles, taking on average 1hour, 5 minutes
Kirkby Lonsdale to Keswick:	42 miles, taking 1 hour, 5 minutes by road
Kendal to Appleby:	25 miles, taking approximately 50 minutes by road

With an overall gradient of 1 in 3 (33%) and up to 1 in 2.5 in places, Hardknott Pass is the steepest road in England. There are five other passes in Cumbria: Wrynose, Kirkstone, Whinlatter, Honister and Newlands.

Rail links can be even more of a challenge, with the main line running centrally through Kendal, Penrith and Carlisle, and branch lines along the length of the Cumbrian coast, within Central lakes area, south of Barrow and on the outskirts of the Carlisle to Settle route.

Barrow to Penrith:	68 miles, taking on average 2 hours, 20 minutes by rail
Workington to Millom:	40 miles, taking on average 1 hour 10 minutes by rail
Carlisle to Staveley:	49 miles, taking on average 1hour, 30 minutes by rail

Many smaller towns and villages do not have rail links at all, so must rely upon bus or car where possible.

Levels of car ownership highlight these contrasts in access between rural and urban areas: In Eden district, only 15% of households do not own either a car or van, compared to 33% of Barrow-in-Furness households. Eden also has the highest level of two-car ownership at 30%.

1348 The Black Death arrives in Cumberland and Westmorland. More than half of the population of England die as a result of the epidemic

1598 The Plague spreads, causing 2,260 deaths in Penrith, 2,500 in Kendal and 1,196 in Carlisle


1832 A major outbreak of cholera affects many British towns and cities
1832
1833

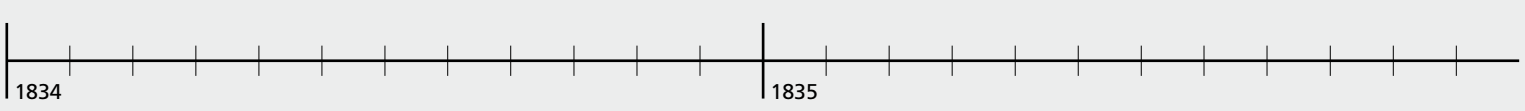
Section 1: The State of Public Health in Cumbria

Public Health in Cumbria has a long and honourable tradition with the appointment of local medical officers of Health going back to 1879 when John Ward MD, was appointed for Westmorland. Our modern-day Directors of Public Health all pay a historic debt to the drive and overwhelming commitment to social reform demonstrated by these early health pioneers. The Reverend Dr. Peter Tiplady, now retired from his post as North Cumbria's Director of Public Health also recognised the contribution of visionaries like Dr John Heysham, who was the first to develop the "Carlisle Life Table". The Life Table was an innovative forerunner to today's area profiles which measured population numbers, longevity by demographic, infection trends, risk factors and mortality levels.

Between 1879 and the present day, the threats to public health in Cumbria have changed dramatically. High birth and infant mortality rates, with young lives often being snuffed out by infectious disease have been replaced by very low birth rates, what would have seemed to our great grandparents to be incredibly low infant mortality and unimagined longevity for increasing numbers of people. As recently as 1948 when the National Health Service was established, women would typically marry in their late teens or early twenties with the expectation of having three, four or five children. I can remember as a medical student in Newcastle in the late 1960s women having their tenth baby. Sixty years ago, the common childhood infections such as mumps, diphtheria, measles, German measles (rubella), chicken pox, meningitis and polio still extracted a significant toll of ill health and early death. Life expectancy for most people reached - at most - into the sixties. For working folk, a few years of retirement in ill-health was the expected fate. Today it is very different with increasing numbers living into their 80s, 90s or even to 100 and receiving their congratulatory telegram from the Queen.

Did You Know…?

Cumbria Primary Care Trust covers the largest geographic area in the North West, covering an area of 2,635 square miles.



Cumbrian Centenarians

> The remarkable achievement of centenarians isn't just the fact that they've made it to 100; it's that they've made living beyond 100 seem a worthwhile goal.[1]

The number of people in England and Wales living to over a hundred has reached an all time high at around 9000.[2]

In Cumbria there are thought to be around 100 centenarians and health trends indicate that this could rise to 2,500 within the next 30 years. This increase can be attributed to improved hygiene and sanitation and better food, housing and living standards, coupled with advancements in medical technology, preventative medicine and health care.

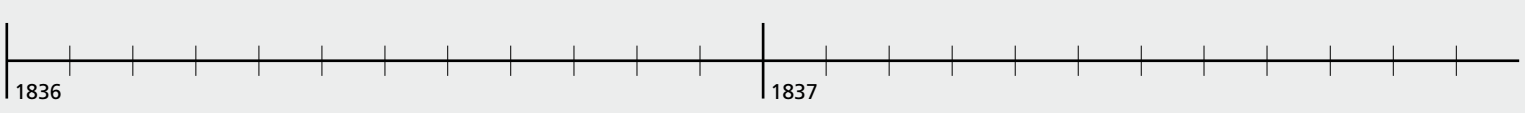
The challenge from a health perspective is that although life expectancy has increased, the average person can spend as much as the last fifteen years of their life incapacitated by chronic diseases. However, some people – described as 'health Houdinis'[3] - live longer than others and avoid serious illness until the very end of life.

> People are ingrained with the idea that the older you get, the sicker you get. It's rather the older you get, the healthier you've been…[4]

So what is the secret of living to a great age in comparatively good health? To find out we asked two Cumbrian centenarians about their life histories and health experiences.

Percy Jones, who is approaching his hundredth birthday, is typical of many centenarians. He has enjoyed robust health for most of his life, only developing problems in the last few years. Despite being registered blind in his nineties Percy lived independently until the age of 98, before moving into a retirement home. But the majority of centenarians are women, like Jennie Hartley, who at 103 must be one of Cumbria's oldest residents. Jennie lived alone for over 50 years after her mother's death in 1952, finally entering a retirement home at the age of 100. Apart from contracting childhood polio[5], over the course of a long life she has needed little medical care until relatively recently.

The conversations we had with Percy and Jennie are helping us to assess the feasibility of a substantial piece of social history research. Obviously we can't generalise from conversations with two people to the experiences of all Cumbria's centenarians, but their stories suggest that while longevity may run in families, other factors such as diet and exercise, and maintaining strong social networks and interests play an important role.



Lifestyle factors

Research has shown that centenarians generally tend to exercise and eat in moderation; this was certainly true of Percy. Although he had a tough start in life typical of the times – combining school with part-time work from the age of eleven – he was always active and enjoyed outdoor pursuits.

Stock photo: NHS Photo Library

I've climbed all the big mountains in my time – not lately – in my thirties. I played tennis in the summer and badminton in the winter. That kept me going because I had a sedentary job – exercise and that. And I like to get out of here [residential home] when it's fine – if it's just walking up and down in the grounds.

Percy has never smoked and eats a moderate but varied diet. He was unconvinced, however, that children growing up today will benefit from the same nutritional foundations for good health.

Young people don't get meals like they used to. We used to eat what was put in front of us of course. I don't think I went short of anything as far as food was concerned. I haven't got a lot of weight on me.

Percy's guidelines for living a long and healthy life reflect received wisdom, therefore.

If we just did many of the things we already know – eating right, exercising, not being obese, not smoking, screening for disease – that would make a huge improvement both in average life expectancy and the proportion of people's lives spent in good health.[6]

Social networks and interests

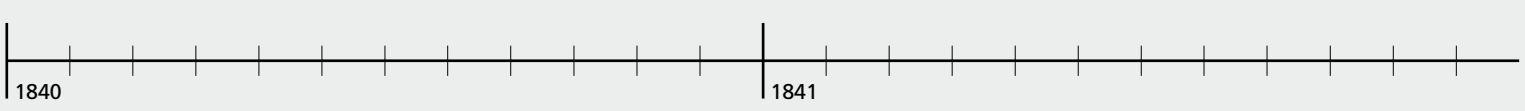
Both Percy and Jennie have maintained particular interests and social networks throughout their lives; although neither had children both have strong family connections in Cumbria. They also seem to have found effective coping strategies to help them age 'successfully'. Percy has a great love of music, sings in a church choir where he is the longest-serving member (by several decades), and has a wide social network. His attitude to everyday life is philosophical – he refuses to worry about what he cannot change and focuses on the positive.

Because childhood polio left Jennie with restricted mobility she took up handicrafts, such as crochet, embroidery and knitting, which she still enjoys. She is also a 'mean Scrabble player' and is happy to join in social activities with other residents when her health permits. Although Jennie has undoubtedly experienced many hardships, she retains a sense of humour and a certain stoical attitude to life, which may well be something that helps her to 'get by'.

Stock photo: NHS Photo Library

Access to health and welfare

While the majority of people probably take the NHS for granted these days, Jennie's account of her early life in Cumbria illustrates how difficult it was for working class families to obtain health care at that time. She explained, for example, that when she



contracted polio in 1911, 'I had to wait 12 months to get into hospital. You had to get some money saved up'.

At the age of 14 Jennie started work at the local knitting factory. Later, when this work dried up, she had to resort to the 'means test', which seems to have been designed to be a humiliating experience.

> Every month they came and saw to you. There was one fellow – he made me walk up and down to find out why I was wearing blooming callipers – as though you wore them for fun. And then on a Thursday I had to take my card and go for…I don't know what they called it but it must have been charity…he [the officer] was called 'Treacle Joe'.

'Treacle Joe' was the relieving officer for the 'outdoor poor' in Dalton in Furness in the 1920s. If people were out of work or sick, instead of money they would receive a voucher for groceries, including such necessities as flour, lard and treacle – hence the nickname[7].

With the introduction of the NHS in 1948 things changed for the better for Jennie – 'before that all my boots and callipers had to be paid for – there was nothing free.' Percy was also positive about the NHS.

> I think on the whole it's been pretty good – the health service. Before that you had to pay – and when you haven't got a lot of money…

1842 Edwin Chadwick's report on sanitary conditions of the labouring population of Great Britain is published, leading to an impetus for public health legislation including the Health of Towns Association

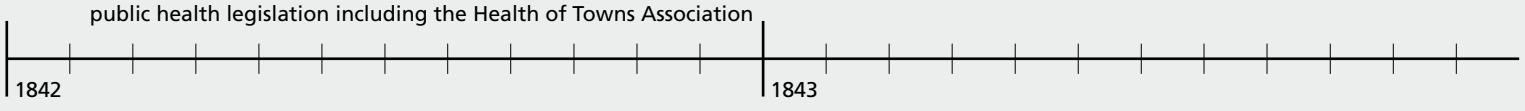
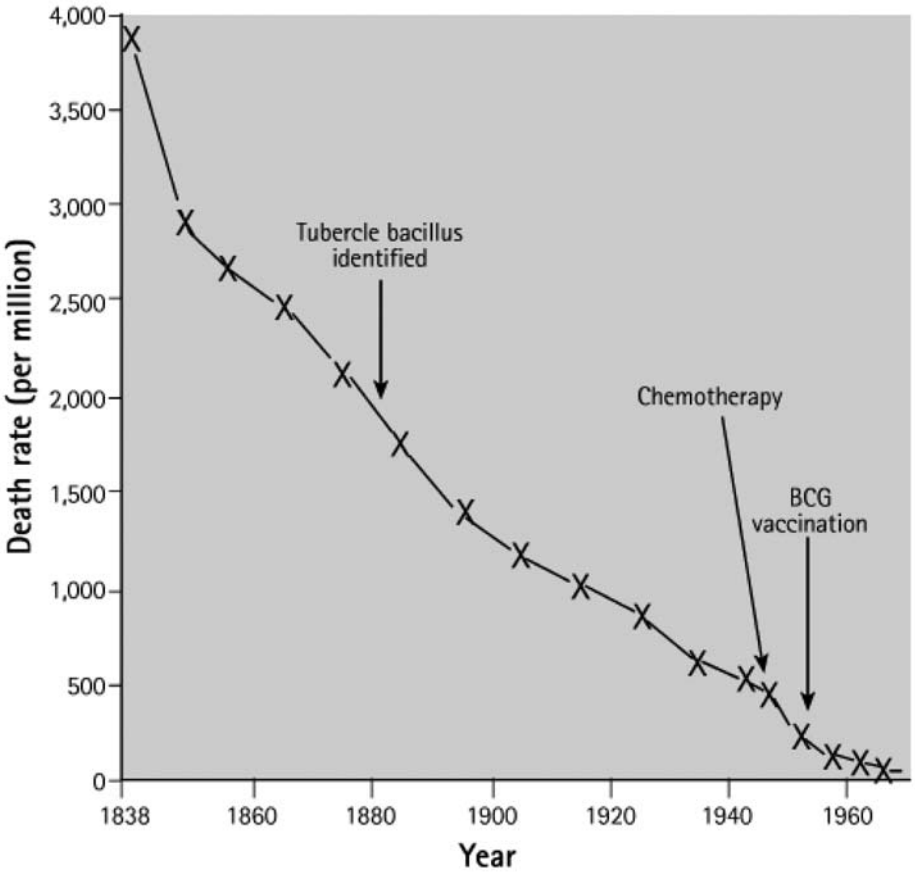


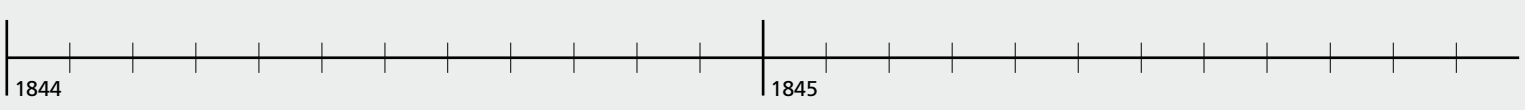
Figure 1: Death Rates from Tuberculosis in England and Wales[8]



Much of the decline in deaths from the tuberculosis took place before we knew what caused it and most of the decline before we had any specific treatment or preventative measure.

The transformation over the past hundred-and-fifty years and even over the last five decades has been remarkable. The establishment of the National Health Service in 1948 is widely regarded as a triumph for Democratic Government in its commitment that all citizens were entitled to equal life chances irrespective of wealth when ill-health struck. As part of the broader based welfare state with universal education, social security and the establishment of labour exchanges, large scale public housing programmes and action to protect the public from environmental health threats this represented the post-war consensus on the need to tackle the five giants of Want, Ignorance, Idleness, Squalor and Disease which threatened social stability both at home and abroad.

The coming of the welfare state and the National Health Service coincided with dramatic reductions in death from infectious diseases of most kinds and there was a tendency in the 1950s and 60s to attribute this phenomenon to the Health Service



itself. It fell to Thomas McKeown, Professor of Social Medicine at Birmingham University, to point out that most of the decline in infectious disease deaths between 1840 and 1970 had already occurred before the discovery of penicillin and that improvements could more appropriately be attributed to smaller family size, improved housing and environmental conditions and better nutrition.

The locally based Public Health system rooted in local government enabled the medical officer of health to contribute to policy and action on local determinants of health through council committees and was a formidable influence for health protection and improvement. Many forget today that when the Health Service was set up it had three parts to it: The hospital, the general practitioner and related community-based medical services (dentists, pharmacists and opticians), and the third arm being the Local Authority public health department with environmental health officers, health visitors, community nurses, social workers and maternal and child health clinics, as well as responsibilities in relation to such matters as food and water hygiene and slaughterhouses.

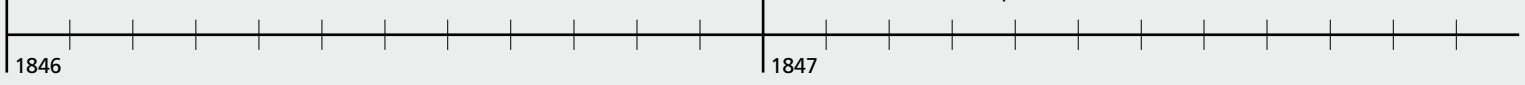
With a changing backdrop and new challenges as people lived longer, non-communicable disease such as heart disease and cancer and long-term conditions related to ageing appeared on the radar and it was concluded that time was up for the Medical Officer of Health and for local government involvement in Public Health. The year was 1974 and local government reorganisation swept away a system which had evolved over 130 years and been copied around the world, not least in the countries of the British Commonwealth where it can often still be seen today.

Did You Know…?

Almost half a million people live in Cumbria.

1846 Liverpool Town Council passes a local act of parliament, the 'Sanatory' Act, enabling them to appoint the country's first Medical Officer of Health

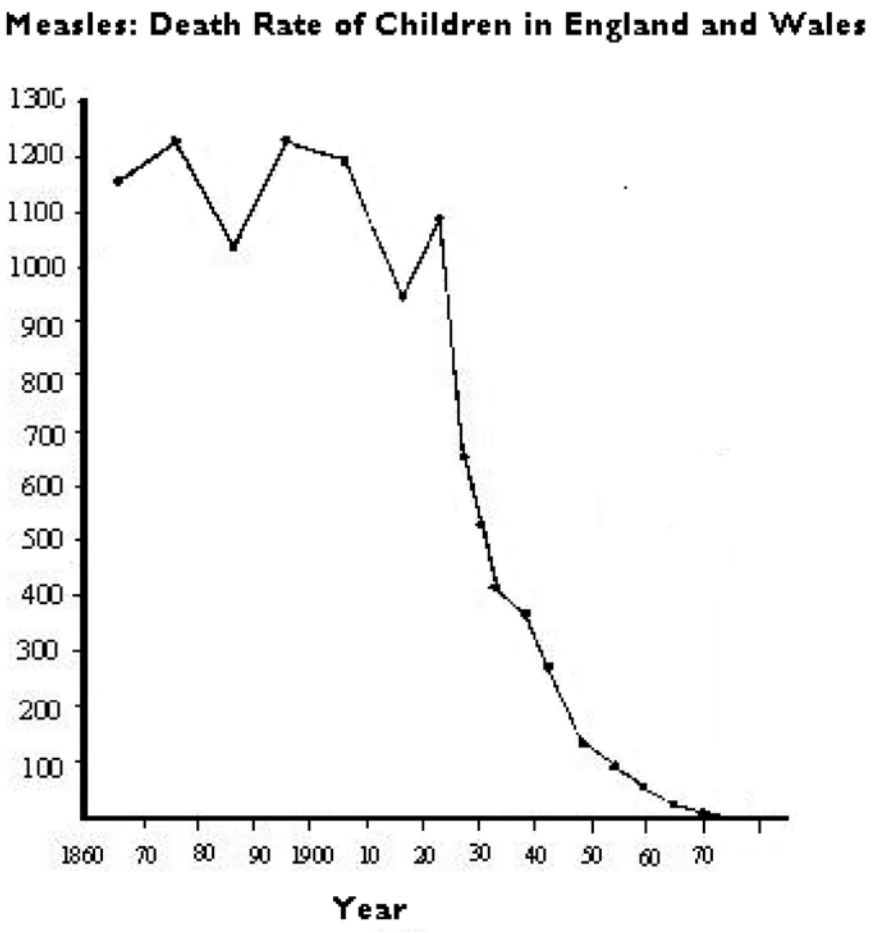
1847 A nationwide typhus epidemic affects the country
William Henry Duncan is appointed the first Medical Officer of Health for Liverpool



Section 2: The Challenge of the New

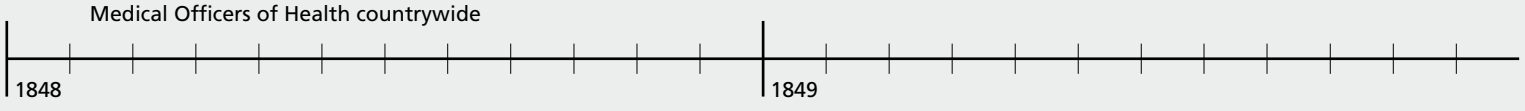
Heart disease and cancer have already been mentioned which together with stroke now account for two-thirds of us one way of another. But infectious disease is still there, lurking and adaptable. Childhood infections such as measles may have all but disappeared, a victory for improved nutrition and living standards coupled with the science of vaccine programmes, almost miraculous in their impact but many other infectious diseases have appeared on the stage.

Figure 2: Death Rates by Measles of Children in England and Wales[9]



Making prevention visible is always difficult and maintaining population coverage with vaccines when the disease in question has hardly been seen in fifty years is a tough call. Since I first came into public health in 1976, the list of new and invigorated infection challenges is ever expanding as can be seen by the list below, not forgetting the return of gonorrhoea and syphilis now resistant to penicillin and some other antibiotics.

1848 Another cholera epidemic hits much of Britain
The Public Health Act is passed by Robert Peel's government, leading to the General Board of Health and adoption of local Medical Officers of Health countrywide



21st Century Infection Challenges

Despite the progress made in eradicating many diseases which affected the population, Public Health workers can potentially be faced with any of these more contemporary infection risks:

New Challenges

- Legionnaires' Disease
- Bovine Spongiform Encephalopathy (BSE)
- HIV/ AIDS
- Ebola virus
- Chlamydia
- Lyme disease
- Avian flu
- Clostridium difficile
- Methicillin-resistant Staphylococcus Aureus (MRSA)

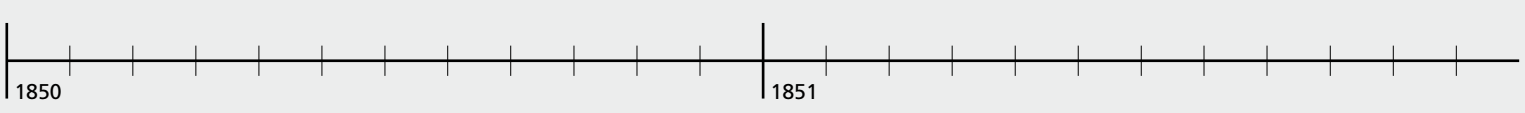
Resurgent Infections

- E-coli O157
- Salmonella
- Tuberculosis

This itself is part of a bigger story which tells how our cavalier use of the gift of antibiotics has led to antibiotic resistance and contributed significantly to the problem of infections acquired in hospitals and other clinical settings. Meanwhile we prepare for the next global epidemic of influenza and plan for a potential mortality rate of 0.4 to 2.5% as forecast by the Department of Health.

Table 1: Potential Flu Deaths in Cumbria during a pandemic peak week

Area	High mortality: 2.5%	Low mortality: 0.036%	Average weekly deaths
Cumbria	**960**	**138**	**105**
Allerdale	185	27	21
Barrow-in-Furness	135	19	15
Carlisle	203	29	22
Copeland	138	20	14
Eden	102	15	11
South Lakeland	198	29	22



As the most obvious threats to infant survival have receded, our understanding of health itself has changed. The possibility of a long life holds out the opportunity for us to use our health as a resource to reach our full human potential. Death itself as an indicator of public health no longer seems sufficient when self-realisation and living the full life becomes intimately entwined with the consumer dream and mental health issues in various forms assume a new prominence. Alcohol, drug and tobacco use cut across the health agenda in many ways. What the philosophers describe as the existential problem of finding meaning in our lives begins to dominate our preoccupations. Death and injury from violence and external causes is a blight on the lives of young adults, and they are often alcohol or drug-related. Many people fail to realise the potential of their adult selves and fall into depression or despair; suicide is a sign of society's failure to respond to the need to belong, feel valued and find meaning in our lives in a post-religious era.

Work by the World Health Organisation on burdens of disease indicates that when other ways of measuring health besides death are used mental health assumes a new prominence.

Figure 3: Cumbria Population Aged 0 - 100+ Years

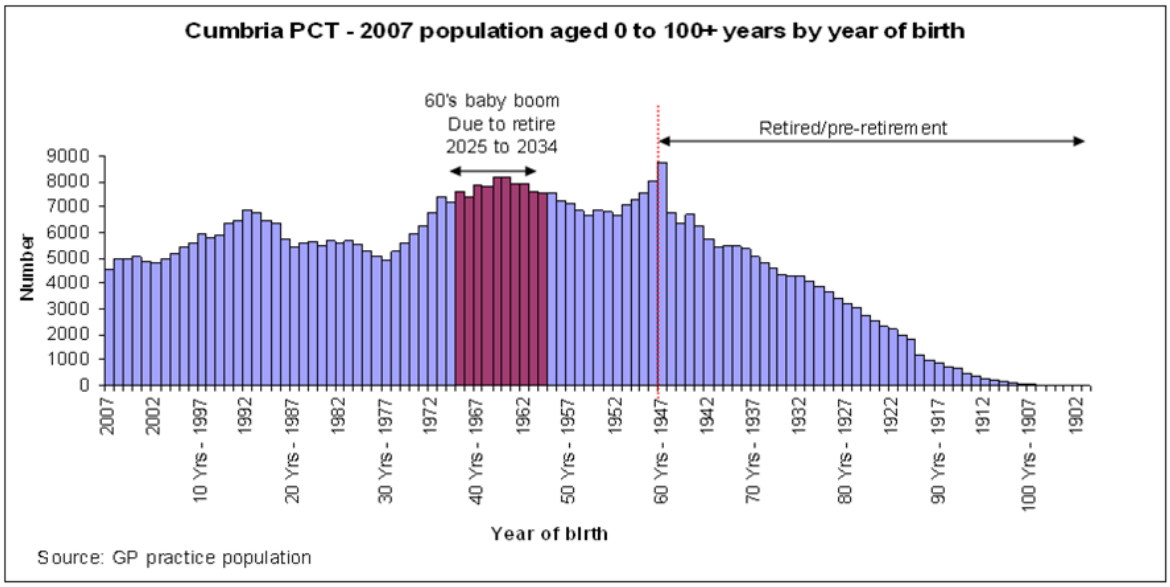


Figure 3 above shows two peaks or bulges in population totals, representing the two successive 'Baby Boom' periods. The first of these was in 1947 when the armed forces came home, with the second running throughout the 1960s. The women are now retiring and the men will retire in four years time. These two bulges are succeeded by much smaller birth cohorts. The oral contraceptive pill came in during the mid 1960s and transformed all our lives.

Figure 4: Population Structure of Cumberland in 1911

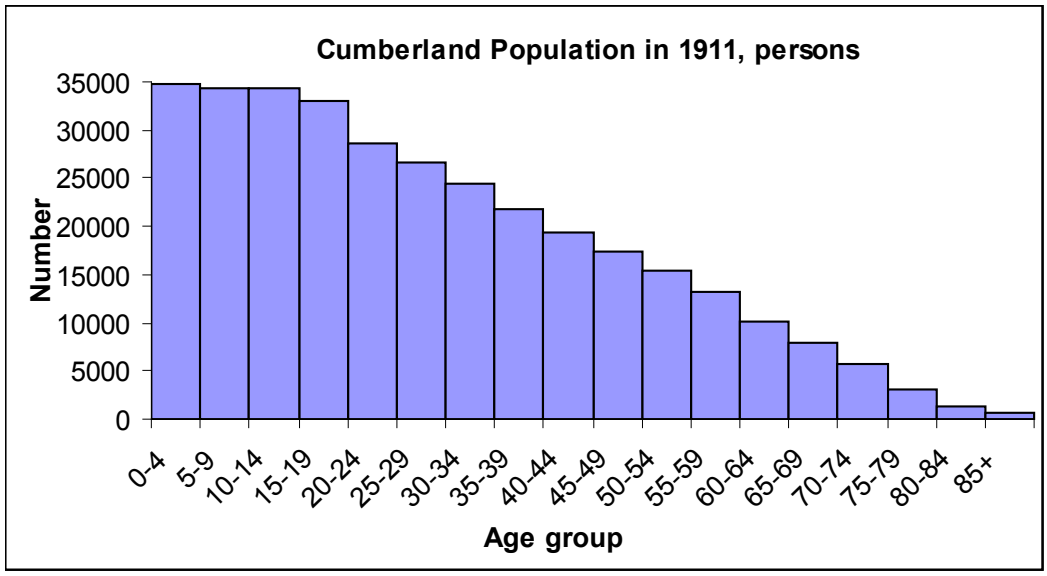
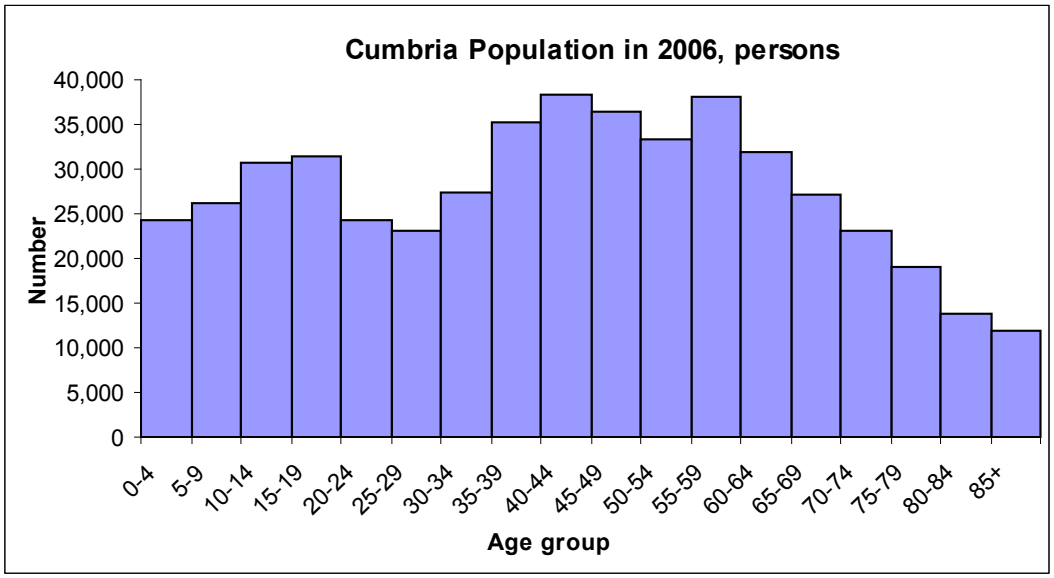
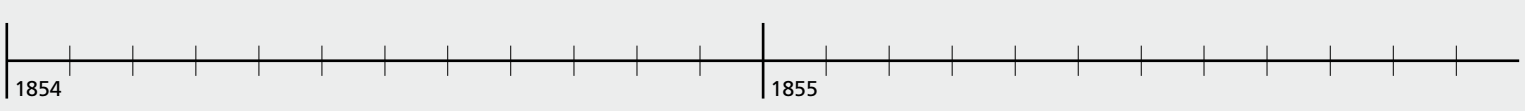


Figure 5: Cumbria Population, number of persons, 2006



For people to live a full life and realise their potential they need robust mental health and coping skills which will carry them through. Yet mental health promotion is in its infancy and we are still stuck with a model of mental health services which is preoccupied with serious mental illness and with institution based care. American psychiatrist Gerald Caplan proposed a very different model for mental health in the 1960s in which psychological and psychiatric expertise was used indirectly to support families, teachers, and others in the front-line of daily living. This public health model has yet to be generally applied in this country.



Further along the age continuum, elderly widows' depression is a particular issue. And with the rapidly ageing demographic especially in Cumbria, dealing with the later years positively despite failing health and the inevitability of death depends on the reservoir of coping skills built up in the best of times and in the early years. We have barely addressed this and have yet to confront the questions surrounding a good death for each of us.

Most importantly, health is not distributed equally across the population and in some ways we are failing to progress in the same universal way that saw the elimination of the childhood infections across social classes. Here in Cumbria, inequalities in health are stark.

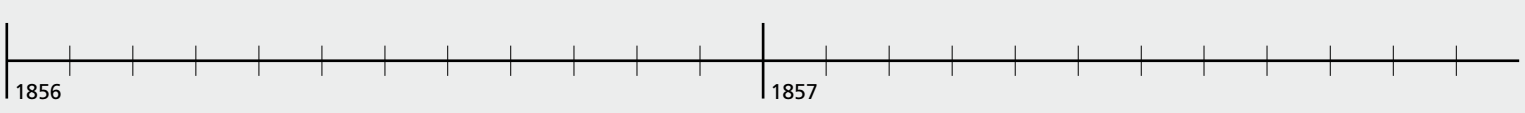
The number of people citing "not good health" in census records is much higher than the regional average, as is the ratio of permanent sickness which is of particular concern in Copeland and Barrow: Against a North West average ratio of 100, Copeland scores 125 and Barrow a staggering 187. Barrow is also ranked tenth in the 2006 list of most Incapacity Benefit claimants in the country, with one in fifty working age adults receiving benefit for long-term sickness.

As part of the economically-challenged North West, we not only live in the region cited with the most inequalities nationwide, but many of Cumbria's districts are also classed as some of the North West's worst areas of health poverty: Our challenge lies in reversing that negative status.

Side by side in Cumbria we have some of the wealthiest people in the country and some of the poorest. The social geography is stark. One of Cumbria's real strengths is the resourcefulness and organisation of local communities. The downside is a parochialism in which concern for those living a few miles away over a fell or across a mountain range may sometime be less than you might hope for. On the world stage we are asked to think globally, and act locally: In Cumbria, we need to build on the strengths of localities but not lose sight of the bigger picture.

Did You Know…?

In 2006, there were 4917 live births and 5384 deaths in Cumbria.



Section 3: The Fully Engaged Scenario

Thomas McKeown's insight into the determinants of health has increasingly permeated health policy both nationally and internationally since the early 1970s, however the domination of the hospital as the mainstay of public health continued to have an unquestionable authority over discussions of resource levels and their use in the 1950s, 60s and into the 70s. Since that time, the pressure for increased National Health Service funding has been more and more met by a response of "Yes, but…" In 2001, banker Sir Derek Wanless was asked by the then Chancellor, Gordon Brown to carry out a review of National Health Service funding to see if increases were justified to bring it up to comparative levels with other Western countries. Sir Derek's response was essentially "Yes, but" - the 'but' being only if we could develop what he called the fully engaged scenario.

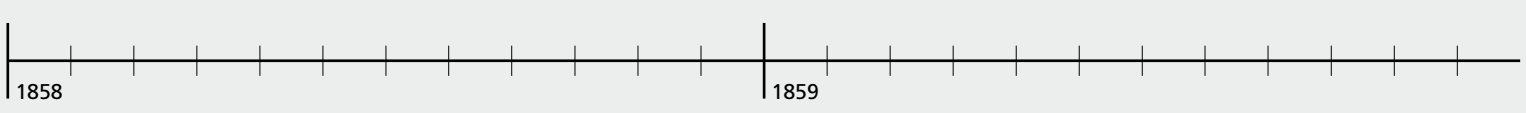
One of the parables most often told in relation to what has come to be described as the New Public Health is that Health and Social Care workers are like lifesavers standing beside a fast flowing river. Every so often a drowning person comes floating down the river; the professionals jump in, pull the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

If we wished we could spend all our money on lifesavers or rescue craft – or hospitals and intensive care units – whilst failing to deal with the preventable factors such as providing 'fencing' and safer environments, warning signs, educating people about the hazards of water or teaching everybody to swim.

In particular, we repeatedly fall into the trap of focusing too much on people's individual risks and behaviours, when the social, economic and environmental conditions in which behaviour is shaped may be much more relevant. In our fear of the Nanny State, we fall into the trap of victim blaming.

In his report for the Chancellor, Sir Derek explained three scenarios for the National Health Service up to the year 2020. In scenario one, it was business as usual - a weak, uncoordinated public health system, variable general practice and community care and the lion's share of resources going into hospitals. At a time of unprecedented increases in life-expectancy, vast inequalities in health would see many older people suffering from several avoidable conditions and cause the National Health Service to fall over well before 2020.

In scenario two, evidence-based best practice would be copied everywhere, but essentially using the same model as now. Professionally-centred and hospital



dominated, the National Health Service would still fall over but more slowly.

In scenario three, Sir Derek explained what he called the fully engaged scenario, in which citizens in partnership with health professionals worked to optimise good health and avoid the avoidable. Strong partnerships between the public and the Health Service, Local Authorities and many others would be the norm and people would have health skills and expertise to help them through life. In this scenario life expectancy rises more quickly, health status improves dramatically and people develop confidence in the health system. The Fully Engaged Scenario highlights the importance of a more productive and flexible workforce, more effective use of technology, policies to promote better disease prevention and putting in place improved incentives to ensure more efficient use of resources.

Did You Know…?

Over 340 young women 18 years old or younger became pregnant during 2005.

Section 4: Choosing Health and Closer To Home in Cumbria

The most recent National Health Service reorganisation has seen a reduction in the number of Primary Care Trusts in England, from 303 to 152 and in the North West from 42 to 24. Here in Cumbria the three previous North Cumbria Trusts — Eden Valley, Carlisle and District and West Cumbria— have merged with the northern half of the old Morecambe Bay Trust to form Cumbria Primary Care Trust with a population of 496,000 people over 2,635 square miles, now the third largest Trust area in England.

The Trust is also the largest in the North West. The geography is challenging; shaped somewhat like a doughnut on an island with communications running north—south, with the east of the county bounded by the Pennines. With four acute hospitals for a population of almost half a million, the new organisation finds itself not only with an inherited £36.7M million deficit but with funding for one hospital when it actually has four. Sir Derek's analysis seems characterised in Cumbria: Not least because of the demographics:

Figure 6: Population Density across Cumbria by District

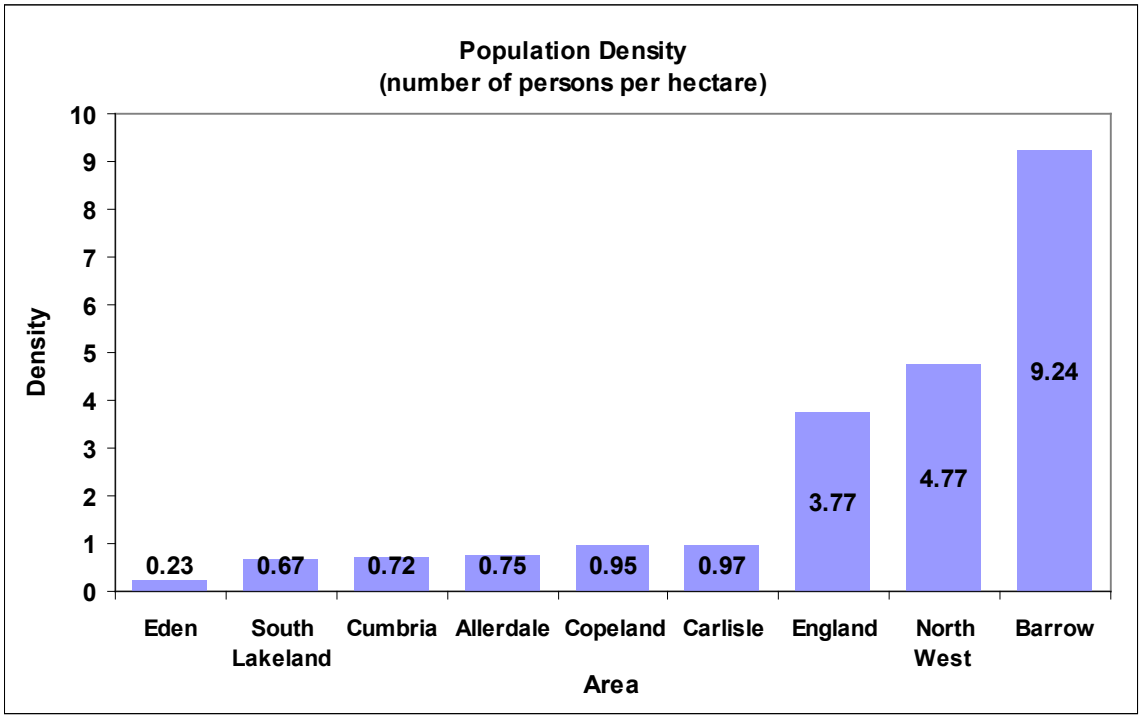
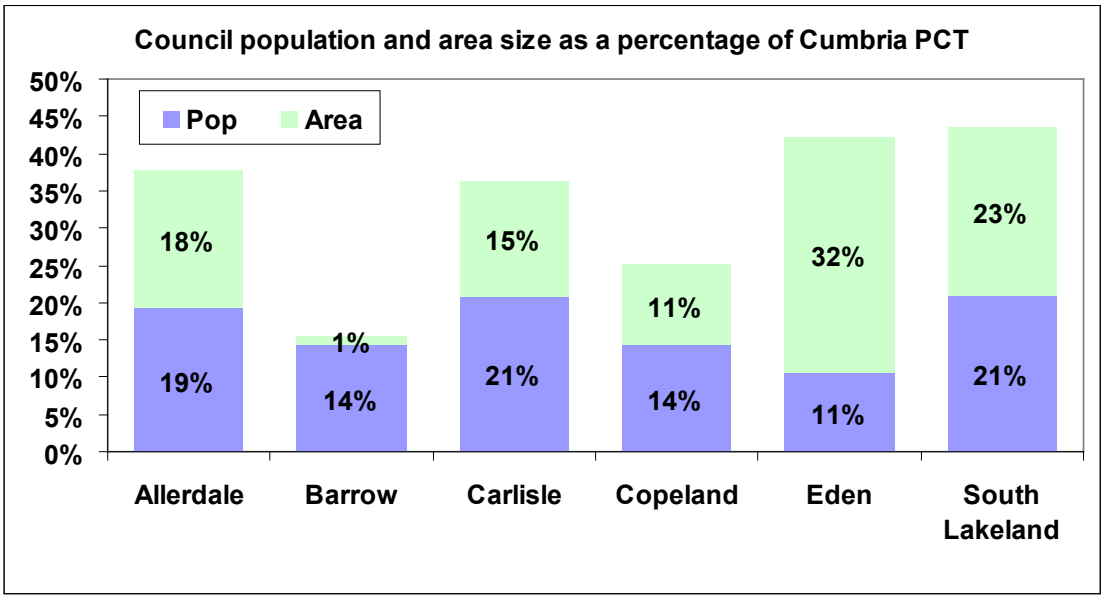


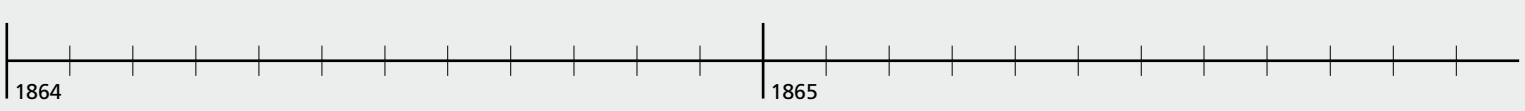
Figure 7: District Council Population and Area Size as percentage of Cumbria PCT



Since coming into existence in Cumbria in October 2006, the new Trust has set about balancing the books and consulting with the people of Cumbria as to how we might craft a health care system fit for the future. Such a system must embrace Sir Derek's fully engaged scenario if it is to survive the next 20 years. It must be 'closer to home' to meet the needs of an ageing population, strive for excellence and managerial efficiency but above all it must be grounded in a public health approach which takes account of the whole population of the county. Close attention must be paid to higher risk groups and areas where people experience particular health problems.

Re-orientating the health and social care system in Cumbria to be not only 'Closer to Home' but also to embrace health and wellbeing is not easy: The big physical geography and unusual social geography with disadvantaged industrial areas cheek by jowl with the traditional rural and with the retiring well-heeled; the shrinking child population and burgeoning population of older people. All these factors put Cumbria in Sir Derek Wanless' front-line. Creating the space to look upstream, to see where ill health is coming from and to tackle the causes requires a clear understanding of the issues and of potential solutions. In many ways mobilising the community, human, natural and engineered resources is a question of lining up all the ducks in a row but finance is also necessary. The recent history of the NHS in Cumbria is not a happy one with the short-sighted diversion of public health budgets to bail out hospital deficits. This is not a recipe for long-term happiness, resulting as it does in a failure to prevent the preventable. It is certainly not fully engaged.

However, the future does look brighter and in the financial year 2008-09 between £2m and £3m has been allocated by the Cumbria Primary Care Trust for specific public



health initiatives. This may sound like a large amount of money but set against a total budget of £713,688,000 for Cumbria it amounts to only about to 0.3%. In comparison we are currently spending £87,721,000 on the pharmaceutical bill, £310,345,000 on hospital inpatient care and £55,802,000 on mental health services, most of which is hospital or clinic based, with only a fraction of that on community mental health and a negligible amount on mental health promotion.

Despite government commitment to making public health a priority a big system such as the NHS has significant inertia when it comes to changing direction. Implementing the 'Closer to Home' agenda could give us a once-in-a-generation opportunity of realising the fully engaged scenario and securing significant health benefit to many of those Cumbrians whose lives are currently cut short before their time or who suffer avoidable ill-health in their later years.

Cumbria Primary Care Trust, along with its health and social care partners across Cumbria, is developing a new vision for healthcare – a vision that brings first-class healthcare and support closer to home.

Closer to Home means in the future people who need health care across Cumbria will get the best possible treatment and support as close as possible to their own homes. When people do need to go to hospital, hospitals would be able to provide faster access to first-class specialised care and services.

Moving health care and services closer to people's homes means:

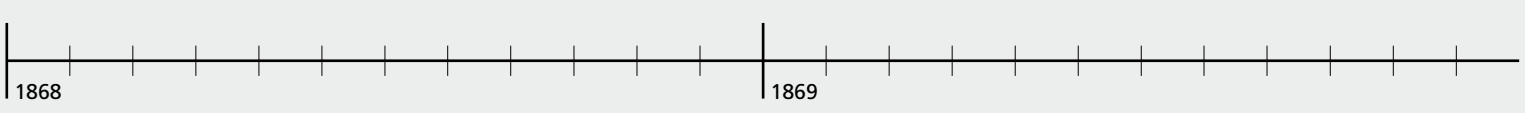
- Health services designed to meet the needs of each local area, making them more responsive to patients
- People with long-term conditions would have more control over their lives and spend less time in hospital
- New and updated facilities in the community which are easy to access
- More care and treatment at home and in community settings would reduce travel times and reduce anxiety of being treated away from home as well as making it easier for friends and family to visit
- Less disruption to peoples' home and social lives as a result of shorter stays in hospital and more local services
- Better and faster access to specialised hospital care
- More highly-trained healthcare teams to provide support in the community

The health and wellbeing agenda implies that we should work together to ensure that all new Cumbrians have a good start in life and an opportunity to realise their dreams and enjoy good health. For each of us the final stages of life are the great unknown. As more and more people reach a great age, improving the quality of care later in life has become a priority. End of life care is now the focus for a great deal of discussion and activity. If we are to enable people to die in the place of their choice following care of their choice we need to take this final taboo out of the closet and have a full grown up public discussion about our options. In some ways the advances in medicine over the past 50 years have resulted in a medicalisation of both birth and death. The era we are now entering will involve re-empowering individuals and their families to make informed choices about the only two certainties that any of us has.

In the Cumbria context, redesigning the health service is about focusing on 'care pathways'. It is essential that this work be informed by good data and intelligence. In particular we need more health profiling and health impact analysis to identify where health gains may be made. We also need health equity audits and evaluations which can clarify the extent to which the NHS in Cumbria is true to the founding value of social justice in health care.

Did You Know…?

The Primary Care Trust area has an older population on average than England: Here over 1 in every 4 people are 60 years old and over, compared to 1 in 5 in England.



Section 5: A Public Health Approach

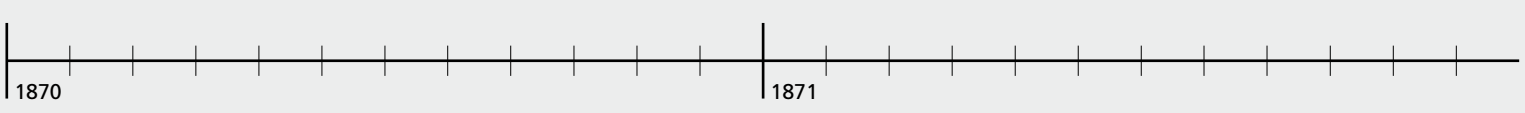
Thomas McKeown was one of the first to describe an ecological way of thinking about the health of human populations. He suggested that animal populations adapt to their habitats or environments and will experience an optimal balance of species health. Changes in population size, migration or changes in the environment and in the interaction with how a species lives in its environment will risk bringing about threats to its health. We are familiar from history with how epidemics have often followed the dislocation of human populations at times of war or natural disaster. What is now apparent from our recent history is the globalisation of trade and travel can have similar impacts and not only infectious diseases such as those referred to but large aspects of lifestyle that are culturally shaped may be involved.

Discovery of the contraceptive pill has revolutionised the lives of women around the world – family size has collapsed as women, no longer slaves of their biology can make real choices as to how they live their lives and whether to have children at all. Almost one in five of all women in their mid 40's in Cumbria are childless while the average number of children each woman will have during her child-bearing years is 1.8; well below replacement level in the medium term.

Table 2: Cumbrian Women, 2005 - Conceptions, maternities and Induced Abortions all ages

	Number of conceptions	Number of maternities	Number of Induced abortions	% leading to abortion
Allerdale	1,089	887	202	19
Barrow in Furness	946	769	177	19
Carlisle	1,426	1,137	289	20
Copeland	930	786	144	15
Eden	572	484	88	15
South Lakeland	949	780	169	18
Cumbria PCT	5,912	4,843	1,069	18
England & Wales	837,444	650,731	186,713	22

Advances in preventive medicine, obstetrics and neo-natal medicine together with improved access to termination of pregnancy have resulted in changes in the number of newborns with congenital abnormalities and malformations. There are less spina-bifida babies being born and those with Downs' Syndrome but many more very low birth weight babies are surviving with disabilities when born at around 24 weeks' gestation. On the other hand, those people who are now born with Downs' Syndrome are living much longer and carry with them increased needs for medical care. Ensuring equal access to services which make a difference remains a challenge.



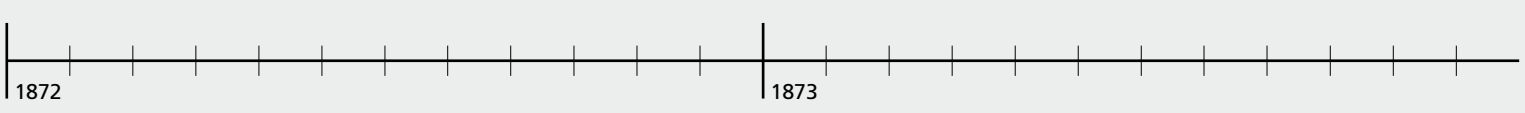
The advent of the teenager, of pop culture as a global phenomenon together with the commercialisation of sex and the ready availability of alcohol and drugs and the weakening of family structures has created a kind of "white-water rafting" for adolescents. This has coincided with changes in the opportunities for teenagers to take on adult roles and responsibilities as the age of full-time education is extended into the twenties or even early thirties – the so-called odysseys. Serial monogamy has to an extent replaced monogamy in society as society adapts to the new biological facts of life in which young people may be biologically old enough to have sex and produce children at the age of 13 of 14 but still be socially adolescent until their late 20s or early 30s.

In Cumbria we have received 3,000-3,500 mostly young adult workers from Eastern Europe in the past ten years. Given a situation where, for every 3-4 Cumbrians leaving work for retirement, there are now only 2-3 school leavers. We will be increasingly dependent on this flow of young workers if we are to staff our businesses and care for the increasing numbers of the elderly.

And in working age, the job for life has gone, economic migration within countries and between them has never been easier with the consequent impact on family networks, social capital and support, and manual work is largely no longer manual. The disappearance of physical work and its replacement by a sedentary lifestyle, underpinned by personal transport and cheap, high-fat, high-sugar foods are the context for the recent dramatic rise in obesity levels with the threat that brings of diabetes and musculo-skeletal problems in later life. This mosaic of modern risks to wellbeing is compounded further by global food and beverage corporations, who market their low-nutrition products particularly to children and young people as insidious but enduring symbols of convenience, luxury and even peer-led social acceptance. Meanwhile, the burden of threat to life from heart disease and cancer has been receding as medical advances have reinforced improvements in nutrition in an earlier era for older people. However, we cannot depend on this benefit continuing.

Spearhead Authorities

Nationally designated by The Department of Health, 70 Local Authorities have been classified as 'Spearhead' areas: These districts represent the worst fifth of Local Authority areas with regards to life expectancy and deprivation as measured for 1995-97. 23 of the 43 authorities in the North West are classed as Spearhead authorities and these include almost two-thirds of the region's population. Accordingly, the North West is one of the most deprived regions of England and fares poorly with regard to not only health inequalities, but also health generally. England and Wales life expectancy at birth continues to improve and for 2002-2004 was 76.5 years for men and 80.8 years for women. Cumbria has two designated Spearhead



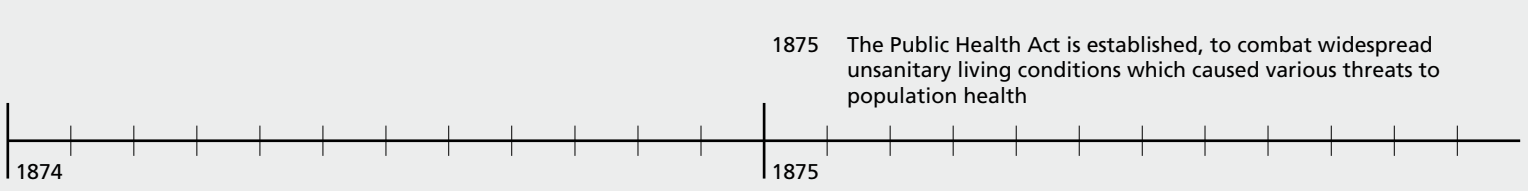
authorities, the boroughs of Barrow-in-Furness and Carlisle and District, both noted for high levels of deprivation within their localities.

Focusing on the gaps highlighted by Spearhead areas across the region, Tom Hennell, Senior Analyst with the North West Public Health Observatory highlights the stark impact of these cultural shifts in his work on contrasting life expectancy gaps across generational population groups[10]:

Table 3: North West Cohort Life Expectancy Gaps in Spearhead Areas – trends 1995/7 to 2003/5

Born 1925 – 1945:
Coronary Heart Disease and cancer death rates decreasing in the North West's Spearhead areas, but not as rapidly as average national improvement.
Born 1945 – 1965:
Death rates from Coronary Heart Disease and cancer improving faster in the North West's Spearhead areas than nationally.
Born 1965 – 1985:
Alcohol-attributed death rates increasing nationally, but more rapidly still in the North West's Spearhead areas.
Born 1985 – 2005:
A big improvement in death rates in the North West spearhead areas, predominantly due to greatly reduced local risk of death from accidental overdoses. Absolute death rates in Manchester and Liverpool are now lower than the national average.
Infants:
Mortality rates under one year of age have improved in North West Spearhead areas, but at a slower rate than nationally. The consequential loss of life years represents a large component of the Life Expectancy Gap.

These multiple effects on health and wellbeing are not fully understood, but what we do know is that beginning in the 1970s, large numbers of people began to live into their eighties and beyond for the first time. In remarkable contrast to such longevity, many young people now experience rapidly deteriorating levels of

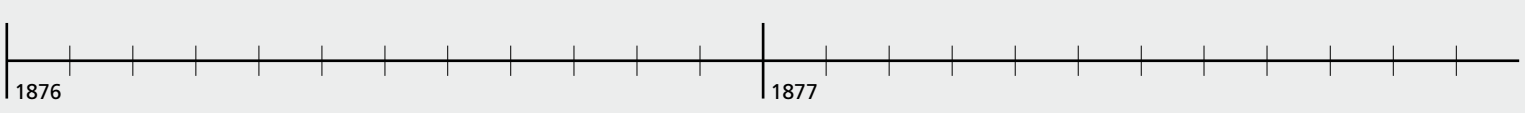


vitality much earlier on in life, as observed through record rates of obesity, mental disorders, alcohol intake and secondary conditions. What we are faced with is a regressive juxtaposition where older generations can often be much healthier than their grandsons and granddaughters and is in contradiction to the goal of increasing healthy life expectancy; this has been described as dying young as old as possible. Those improvements that have been gained have not been shared equitably with huge differences opening up between different parts of the county and between different groups of people.

As the pace of 21st Century life becomes increasingly associated with an upsurge in risky coping strategies, the cultural reliance upon smoking, recreational drug use and binge drinking all inevitably contribute to ill health and premature death. Binge drinking alone can lead to cirrhosis of the liver and alcohol-related violence, sometimes resulting in emergency admission to hospital. Whilst alcohol-related illnesses undoubtedly impact on the middle aged, binge drinking is of increasing concern with teenagers and young adults. In a county where 'nothing to do' is often bemoaned by its youth, drinking is seen as a core recreational activity; a scenario which lays the foundation for complex health and social problems in the future. This sorry picture is reflected in the ranks of alcohol consumption in the North West, with West Cumbria, north Cumbria and Barrow closely behind the highest problem areas of Merseyside and Greater Manchester.

The implications of this are now in the pipeline and underpin Sir Derek Wanless' cautionary analysis of unprecedented over-demand for too few health care resources. In the next two crucial decades, the number of people aged 85 and over in England is set to increase by two-thirds, compared with a 10 per cent growth in the overall population. If we look back a similar length of time, between 1981 and 2001 increases in healthy life expectancy did not keep pace with improvements in total life expectancy, leading to a sharp increase in chronic conditions.

Taken together, it has been suggested that we could have to contend with an increase of more than 50% of people with maturity onset diabetes[11] and up to a 50% increase in the numbers with dementia[12] over the next 20 years unless we get our act together with public health. The huge variations and inequalities in the quality of life and ill-health throughout life but especially in the second half, i.e. the over 50's underlines the challenge.



Section 6: Situation Analysis

The population of Cumbria was 487,607 at the 2001 census. The latest mid-year estimates for 2006 show that this has increased to 496,000 people.

Table 4: Cumbria Population 2006, in 1,000s

Cumbria population, 2006													
	0-4	5-9	10-14	15-19	20-34	35-49	50-64	65-69	70-74	75-79	80-84	85+	All Ages
Males	12.5	13.5	16.0	16.4	37.8	54.6	51.4	13.3	11.0	8.2	5.2	3.4	243.3
Females	11.8	12.7	14.8	15.1	37.4	55.5	51.8	13.8	12.1	10.7	8.5	8.5	252.7
Persons	24.3	26.2	30.8	31.5	75.2	110.1	103.2	27.1	23.1	18.9	13.7	11.9	496.0

The most recent population projections show that by 2029 Cumbria's population is expected to grow by seven percent to 529,600. However, this growth is not evenly distributed across the county with an 18 percent increase in Eden, whilst the population level in Barrow-in- Furness is projected to fall by two percent.

Table 5: England, Cumbria and District Population Change Projection to 2029

2029 projection	Change
England	13%
Cumbria	7%
Allerdale	3%
Barrow-in-Furness	-2%
Carlisle	9%
Copeland	-1%
Eden	18%
South Lakeland	15%

The population may be growing but in what way? Projections show that Cumbria could have an increase of 64,000 people aged 65 years and above. This contrasts with a decrease of 29,000 people aged below 65. It is projected that Cumbria will have 16,000 fewer young people (under 19 years old) with Copeland experiencing the greatest decrease at 3,700. What is paradoxical about Cumbria, in particular Eden and South Lakes, is that whilst there are more deaths than births each year the population is increasing, This is the result of a combined effect of retirees entering the county and people living longer once here.

If projections are correct Cumbria will have a greater proportion of people aged over 65 than the national average. An additional 14,000 people will be surviving past 85 years of age with just over 4,000 of them living in South Lakeland, with dementia rates of up to one-third. A much larger older population will create a much greater demand for health services and have considerable knock-on effects upon provision within the county. More older people who are in turn living longer generates a qualitatively different level of medical need.

Figure 8: England and Cumbria Projected Population Change percentage between 2004 and 2029

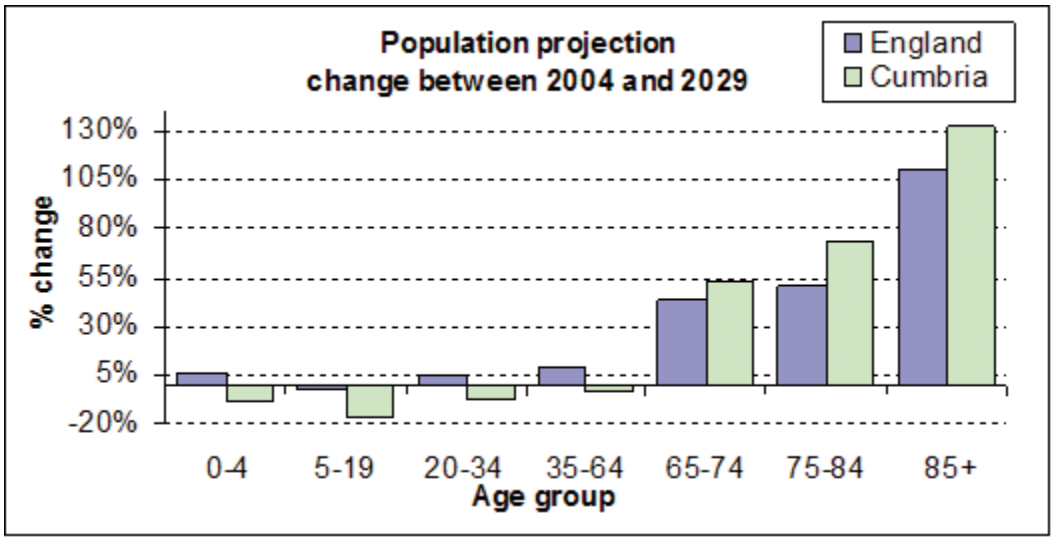


Figure 9: Cumbria Districts Change in Population Numbers 2004 to 2029, in under 65 and over 65 year olds

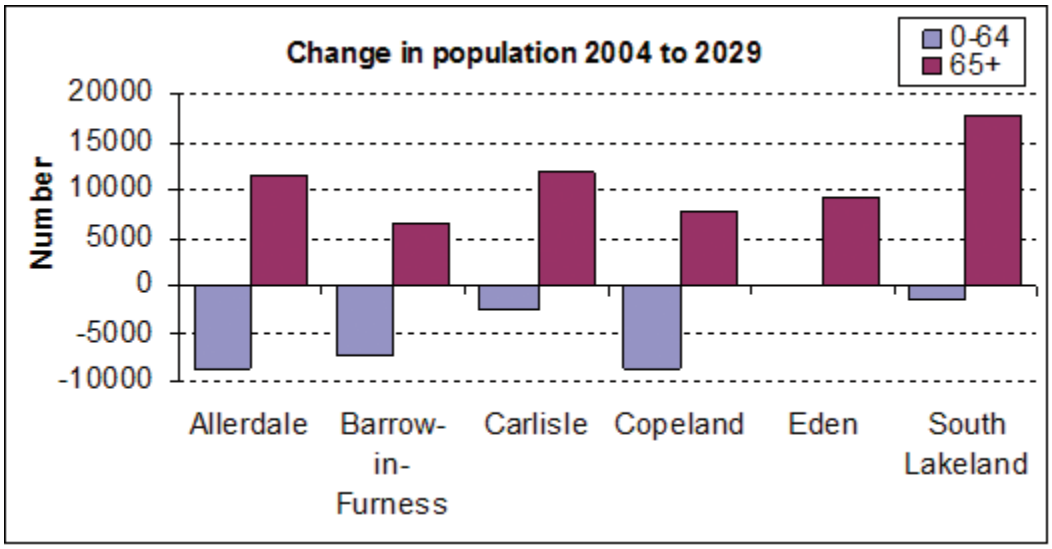
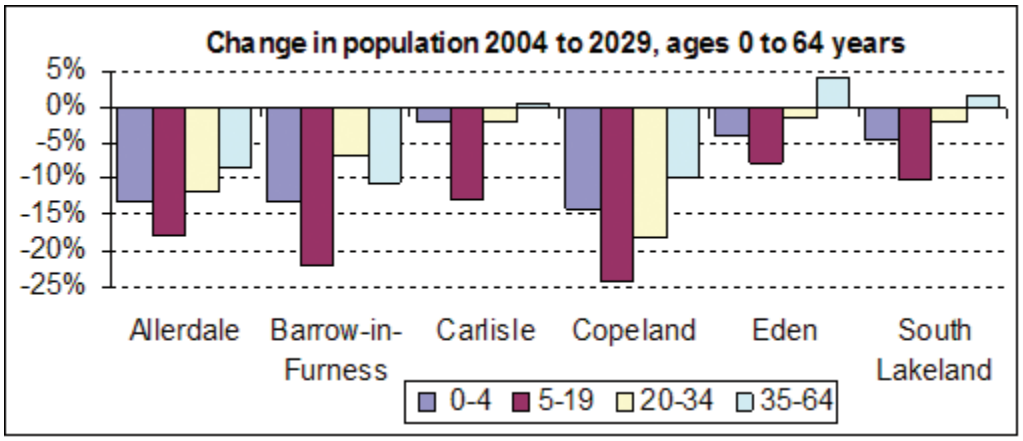


Figure 10: Cumbria Districts Change in Population by percentage, 2004 to 2029 - ages 0-64 years



More recently, migrant workers have found employment in our local industries. It is hard to gauge how many have come to Cumbria, but the latest figures for 2007 taken from GP practice registers suggest that over 2,500 migrants have signed up with a local doctor. Over one-third have arrived from Poland alone. Well over a third of all migrants have settled in the Carlisle area, whilst two-fifths live in South Lakeland and Allerdale. Eden and Copeland have attracted one fifth of migrants, while migrant workers have made much less impact on the Barrow-in-Furness economy.

On average, about 90 babies are born each week in Cumbria to increasingly older mothers. In the past typically, women would have their first baby when they were in their late teens or early twenties. Today, 56 percent of mothers are aged between

1882 Robert Koch isolates the tubercle bacillus, the bacterium that causes tuberculosis

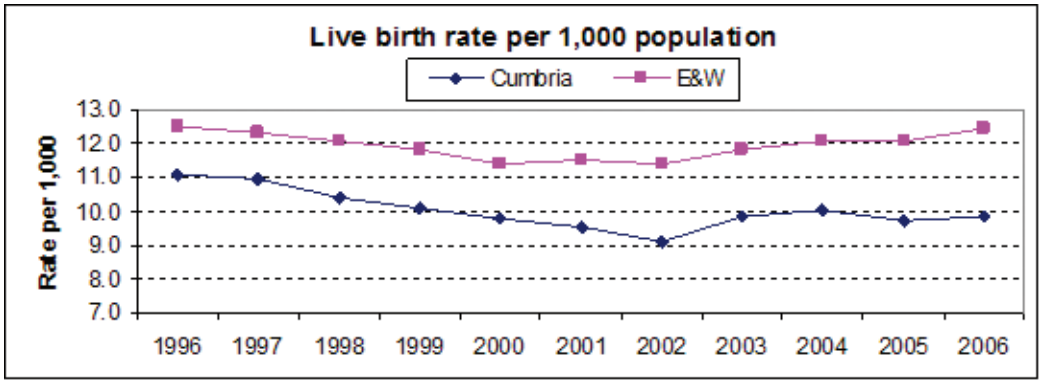
1882-1894 Alexander Hogg, Workington Borough Council

1883

25 and 34 with the average age of mothers being 28.9 years. Women are not only choosing to start their families later in life, but are also opting for fewer babies. The Total Period Fertility Rate measures family size; this is the average number of children you would expect a woman to give birth to during her child bearing years. Nationally, this rate is 1.85 children for every woman living in the country, but Cumbria falls just below this at 1.83 children. Figures peaked for those women born in 1934 with 2.46 children, and this peak corresponds with the 1960s "Baby Boom". Both the national and Cumbrian rates are well below that required to replace the population at its current level in the longer term.

Until the 1970's, the local birth rate was greater than the death rate. Last century saw births peak in 1924 with a rate of 24.6 babies born per 1,000 people. In contrast, today's rate of 9.9 babies is even below the 1940 wartime low of 10.6, although recent years have seen a slight recovery from the turn of the 21st century's low rate of 9.4 births.

Figure 11: Cumbria Live Birth Rate per 1,000 of the Population



Looking at recent figures for the districts, Barrow-in-Furness, Carlisle and Copeland have birth rates higher than the Cumbria average. The remaining areas have lower rates with South Lakeland in particular showing a downward trend.

Figure 12: Cumbria Live Births Crude Rate per 1,000 of the Population

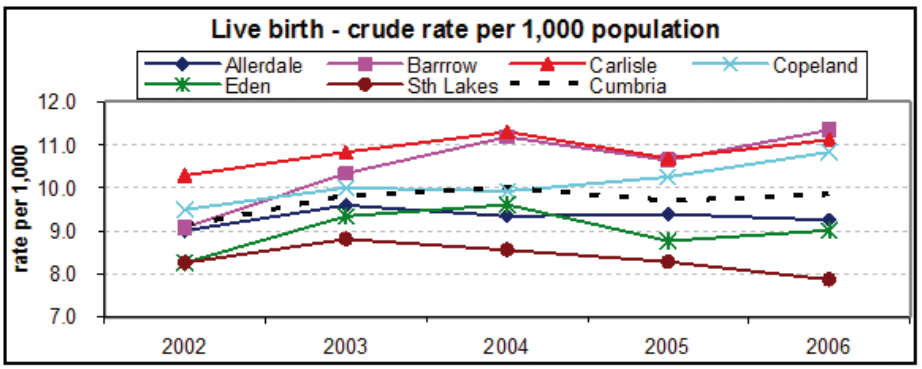


Table 6: England & Wales, Cumbria & Districts Total Period Fertility Rate 2006, Women aged 11-49

Cumbria 2006 total period fertility rate (women aged 11 – 49)	
Copeland	1.99
Barrow in Furness	1.89
Eden	1.88
Carlisle	1.87
Eng & Wales	1.85
Cumbria	1.83
Allerdale	1.80
South Lakeland	1.61

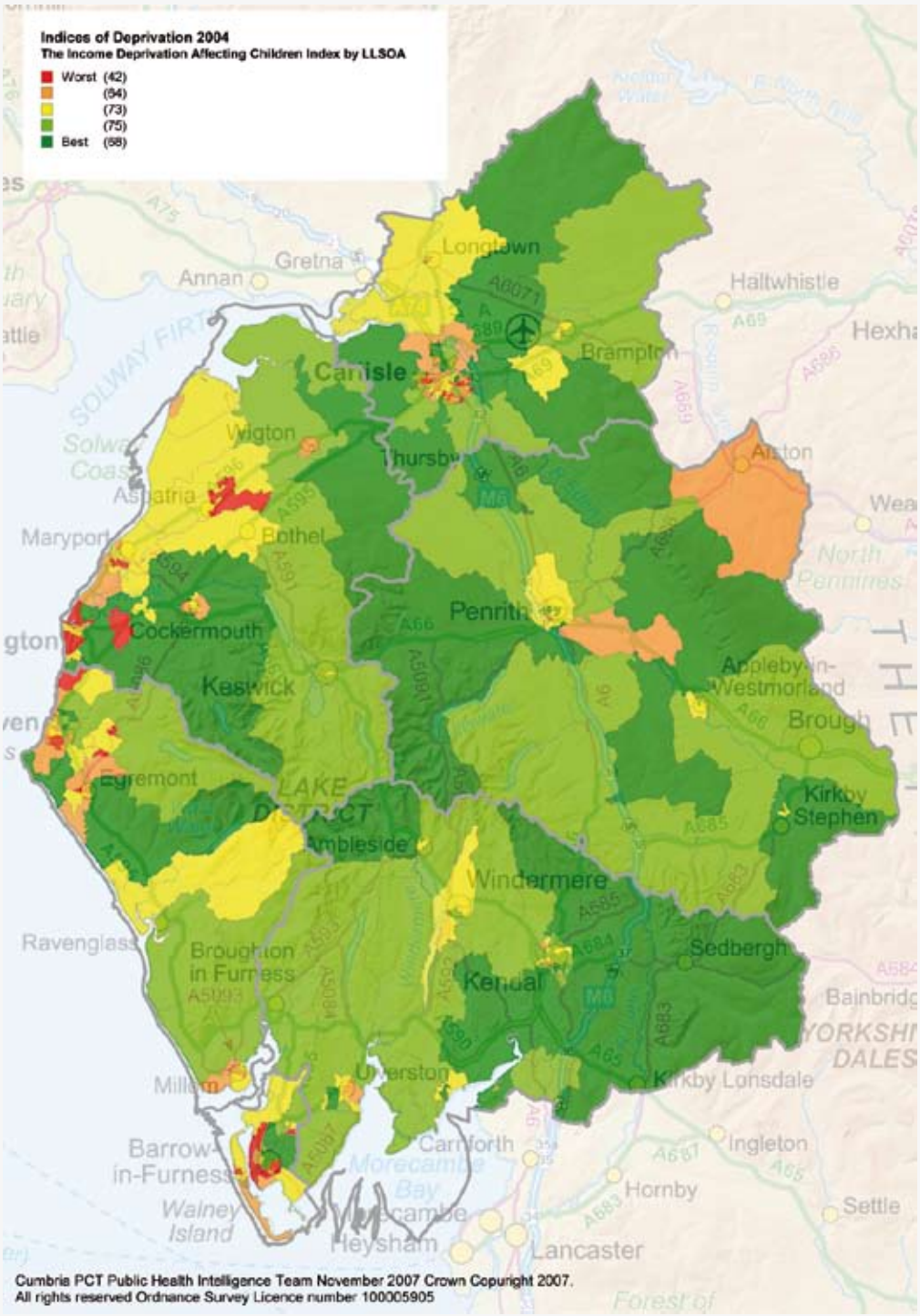
Nationally in 2005, nearly one in five women in their mid forties was childless compared with one in ten women in the 1940s. An interesting picture appears when looking at the total period fertility rate for 2006: Copeland tops the table with a rate of 1.99 children for every woman. It is hard to say why fertility levels are higher in certain parts of Cumbria, but personal choice, career opportunities, social class and environment all play a part. However, if population projections are correct and Cumbria's younger population is in decline, sustaining current fertility rates will be difficult unless there is an influx of younger people into the area.

The majority of young (20-35 years) migrant female workers are finding employment in Carlisle and South Lakeland, but whether they choose to settle in Cumbria and start a family is another matter. Ironically, improving levels of educational achievement across Cumbria is likely to exaggerate declines in fertility further as women who stayed on into higher education are likely to have fewer or no children.

Whatever happens to the birth rate in Cumbria, mothers should have the choice of where they give birth, be this in hospital or at home. The National Service Framework for Children, Young People and Maternity Services 2004 actively promotes midwife-led care for women and where they wish it and it is low risk recommends that healthcare providers should develop midwife and home birth services to meet the needs of their local population.

Giving birth today is very safe compared with the start of the 20th Century: In 1928, a woman faced a 1-in-290 risk of dying during childbirth, while today a pregnant woman faces less than a 1-in-19,020 risk of dying. Over the past six years there have been fewer than five deaths due to childbirth in Cumbria. Nowadays post–natal depression is a more common complication that one in six new mothers may have to cope with and they may be affected by for up to two years after giving birth. The prevention of post-natal depression includes measures to ensure that the birth is not over-medicalised, that women have choice and that the childbirth is an authentic experience.

Figure 13: Index of Income Deprivation Affecting Cumbrian Children

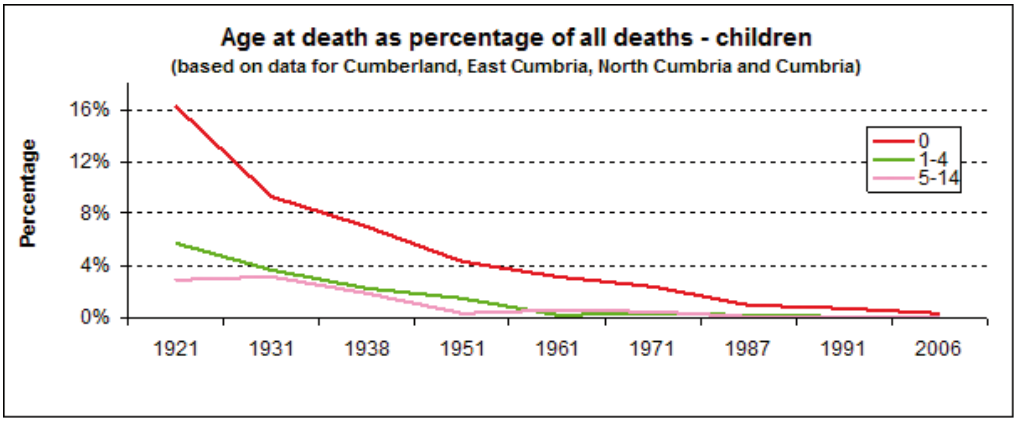


This is a subset of the Income Deprivation Domain and comprises the percentage of children under 16 who were living in families in receipt of Income Support and Income Based Job Seekers Allowance or in families in receipt of Working Families Tax Credit / Disabled Person's Tax Credit whose equivalised income is below 60% of median before housing costs.

Born in Cumbria

Being a child at the beginning of the last century was a risky business. In 1921, one out of every twelve babies born died before reaching their first birthday; a staggering 16 percent of all deaths. As the century progressed, infant survival improved with increasing numbers of babies living past their first birthday. In 1951, one baby died for every 30 born, with infant deaths making up seven percent of all deaths. Moving forward to today, of the 4,917 babies born in 2006, 23 did not survive their first year; in other words one death for every 214 births.

Figure 14: Cumbria Children age at death as percentage of all deaths 1921-2006



Of these 23 deaths almost half died within the neonatal period – the first 28 days of life. The main causes of death amongst neonates being pulmonary immaturity (particularly where there has been a premature birth), congenital anomalies and infection. For those infants who died in the post neonatal period again respiratory problems were the greatest threat to life with congenital anomalies being the second major cause of death.

Table 7: Cumbria Infant Mortality Rate and Low Birth Weight Rates per 1,000, 2006

2006	Infant mortality rate	Low birth weight
Allerdale	5.6	5.7%
Barrow in Furness	2.5	5.6%
Carlisle	2.6	7.9%
Copeland	3.9	5.8%
Eden	8.4	6.7%
South Lakeland	7.4	6.3%
Cumbria	4.7	6.4%
England & Wales	5.0	7.9%

In recent years infant mortality rates in Cumbria have been below those of England and Wales; Infant mortality is death occurring in the first year of life and is commonly related to respiratory problems or congenital malformations. However, when looking in more detail at what is occurring within Cumbria, a different picture emerges.

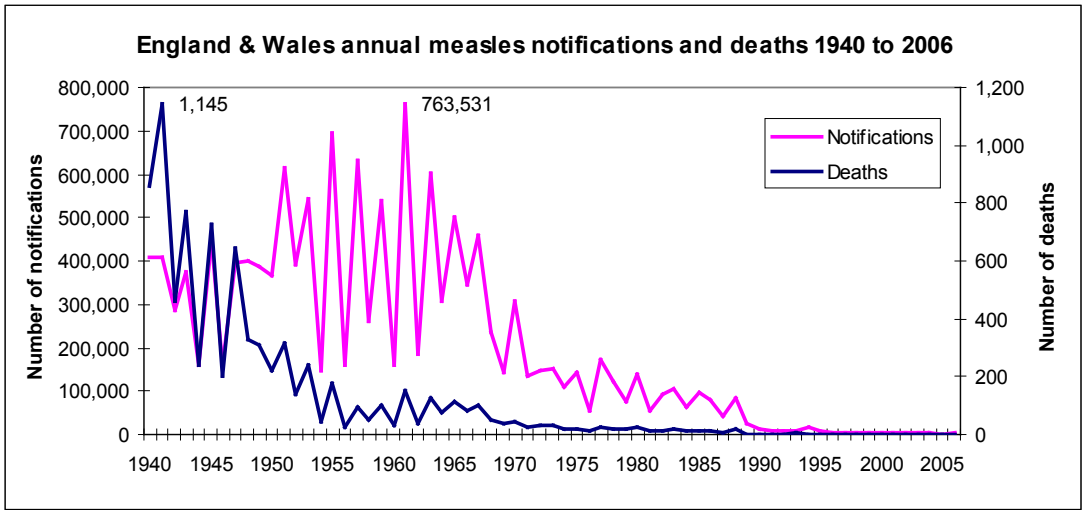
In Barrow-in-Furness in 2006, the infant death rate was 2.5, which contrasts with the higher rate of 8.4 in Eden. If each district experienced the same low rate as Barrow-in- Furness, there would have been eight fewer deaths. However, it must be remembered that when working with such small numbers an additional death can make a huge difference to the resulting rate.

Birth weight is an important indicator of a baby's health. Nationally 7.9 percent of pregnancies result in a low birth weight (less than 2,500 grams) baby, which may place it at risk in the early days of life. Again, Cumbria is below the national average with a figure of 7.2% of low weight births, with differing rates occurring throughout the districts. If the Barrow-in-Furness level of 5.6 percent prevailed throughout the county there would have been 41 fewer low birth weight babies.

Pre-school years

During the last century significant improvements have been made in survival rates for children aged one to four years. In 1921, six percent of all deaths were for children in this age group. By 1951, this figure had fallen to two percent. During 2006 there were 5 deaths in Cumbria. Contrast this to 1951 when, in the former County of Cumberland, an area smaller than Cumbria, there were 43 deaths. Details of recorded cause of death for these children are not readily available, but the preventable but common childhood illnesses of measles and whooping cough would have accounted for some of them at that time.

Figure 15: England and Wales Annual Measles Notifications and Deaths, 1940-2006



The introduction of childhood immunisation programmes has seen not only a decline in the number of deaths from these infections, but also a massive fall in the number of cases of the disease in the community. The last confirmed case of measles in Cumbria was in 2001 in Keswick.

1892

1893-1897 C Gore Ring, Keswick Urban District Council
1893-1897 Henry Barnes, Cumberland County Council
1893-1909 S F McLachlan, Longtown Rural District Council

Table 8: Cumbria Children unprotected from measles, mumps and rubella in March 2007

Children unprotected from measles, mumps and rubella		
Area	2 years of age	5 years of age
Allerdale & Copeland	104	191
Barrow & South Lakeland	179	286
Carlisle & Eden	145	275
Cumbria	428	752

However, we should not become complacent as history and the Third World remind us that these childhood infections are killers. The World Health Organisation recommends that at least 95 percent of children receive a measles vaccine by two years of age. In Cumbria on the 31st of March 2007, there were 428 children aged two who were not protected from measles. For the same period, there were also 752 five year olds who had not received their second dose of MMR vaccine.

On average, a child aged below 5 years of age will visit the GPs surgery six times a year, be it for their "jabs" or their carer seeking advice on the child's health. Sometimes the problem is more serious and the child will be admitted to hospital. Over half of all admissions to hospital for children in this cohort can be accounted for in three groups: Respiratory diseases, no specific diagnosis, and infectious diseases. The majority of these children will be admitted as an emergency with those aged under one year spending an average of four days in hospital, while those aged between one and four will be admitted for one day on average.

Did You Know…?

Ischaemic Heart Disease or reduced blood flow to the heart, is the most common cause of death in Cumbria and affected 551 men and 455 women in 2006.

1894-1914 Robert Musgrave Craven, Kendal Borough Council
1894 William Brown, Carlisle City Council
1894-1910 John Highet, Workington Borough Council
1894-1897 D.G. Pearce Thompson, Penrith Urban District Council
1895

Table 9: Cumbrian Hospital admissions by main diagnosis: Finished Consultant episodes 2006-7, children aged 0 to 4 years

Conditions	<1	1 to 4	Total	
Respiratory diseases	239	1092	1331	23%
Symptoms & signs not elsewhere classified	265	664	929	16%
Infectious & parasitic diseases	165	564	729	12%
Conditions originating in perinatal period	569	23	592	10%
Digestive diseases	114	332	446	8%
Injury & poisoning	41	396	437	7%
Congenital malformations	158	201	359	6%
Ear diseases	5	212	217	4%
Genitourinary diseases	22	144	166	3%
Examination & investigation	38	110	148	3%
Neoplasms	8	104	112	2%
Skin diseases	19	82	101	2%
Musculoskeletal diseases	4	73	77	1%
Nervous system diseases	21	48	69	1%
Eye disease	5	49	54	1%
Blood & blood forming organs	0	39	39	1%
Endocrine & metabolic disorders	4	24	28	0%
Unknown	4	15	19	0%
Circulatory diseases	4	14	18	0%
Mental & behavioural disorders	0	9	9	0%
All episodes	1685	4195	5880	

Health in school years

Once a child enters their school years, they will still visit the doctor's surgery on occasion, on average twice a year between the ages of 5 and 14. Young women aged between 15 and 19 will start visiting the surgery more frequently, perhaps for up to four times a year, whilst their male counterparts visit on average twice a year. The likelihood of admission to hospital falls, but when this age group is admitted it is probably as a result of their riskier behaviour as 16 percent of episodes of 5-to-18 year olds are for accidents. In this particular group, those between 15 and 18 years are more likely to be injured and some young women attend because of pregnancy. Of all admissions to hospital, children and young people in the age group 5 to 19 make up seven percent of all admissions and are likely to stay in hospital for an average of 1.7 days. At this age we see the beginnings of a pattern which will stay more with males than with females until they are in their 30s, with hospital treatment being required as a result of accidents or violence which is increasingly alcohol related. This

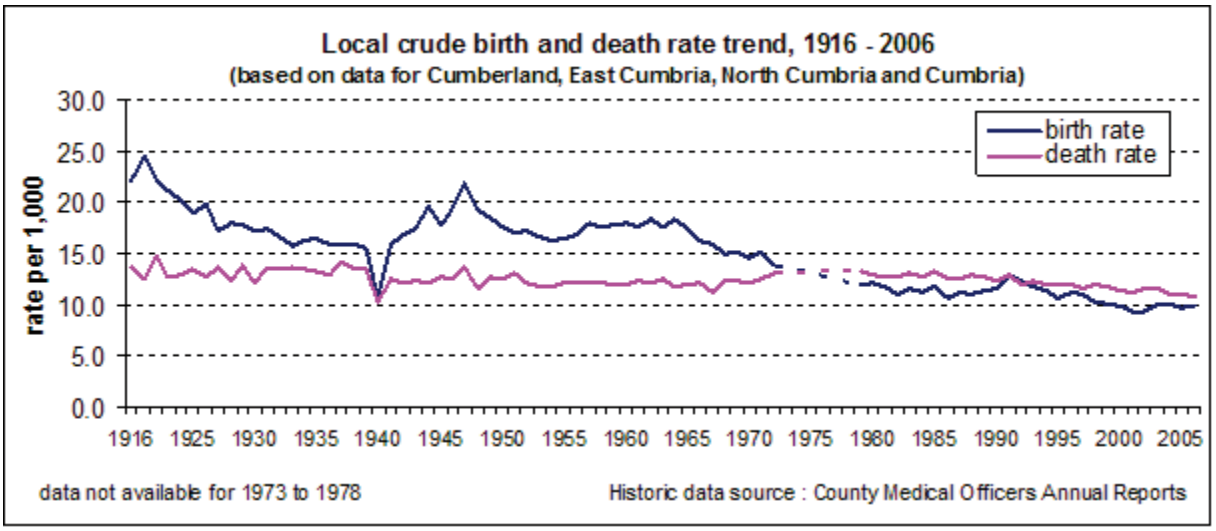
is reflected in the impact of excess male deaths over female on the gender balance – what had been an excess of males at birth has become an equal balance at age 20-34.

Table 10: Cumbrian hospital admissions by main diagnosis: Finished consultant episodes 2006-7, children and young people aged 5 to 18 years

Conditions	5 to 9	10 to 14	15 to 18	Total	
Injury & poisoning	333	403	562	**1298**	16%
Symptoms & signs not elsewhere classified	275	399	397	**1071**	13%
Digestive diseases	292	368	356	**1016**	13%
Respiratory diseases	454	251	211	**916**	11%
Pregnancy	0	0	622	**622**	8%
Genitourinary diseases	133	142	108	**383**	5%
Musculoskeletal diseases	71	128	162	**361**	4%
Ear diseases	251	72	37	**360**	4%
Neoplasms	79	134	84	**297**	4%
Examination & investigation	90	93	88	**271**	3%
Infectious & parasitic diseases	145	77	36	**258**	3%
Congenital malformations	88	90	44	**222**	3%
Skin diseases	48	79	90	**217**	3%
Nervous system diseases	62	66	65	**193**	2%
Endocrine & metabolic disorders	48	63	70	**181**	2%
Mental & behavioural disorders	8	32	82	**122**	2%
Blood & blood forming organs	53	41	20	**114**	1%
Eye diseases	40	28	22	**90**	1%
Circulatory diseases	21	30	36	**87**	1%
Unknown	12	12	17	**41**	1%
All episodes	**2503**	**2508**	**3109**	**8120**	

Mortality amongst this age group is low. In Cumbria in 2006 there were thirteen deaths between the ages of nine and eighteen. Tragically, car accidents accounted for five of these, with infections as the second major cause of death. In a typical cohort of 5,000 Cumbrian children, 34 will have died by the age of eighteen and contributed to hospital admissions by some 7000 consultant episodes.

Figure 16: Cumbria and its districts local crude birth and death rate trend 1916-2006



If perinatal and infant deaths have reduced dramatically in Cumbria over the past 100 years so too have they amongst adults, both absolutely and relatively.

Table 11: Deaths in Cumbria, numbers by age group, 2006

	Males	Females	Persons	
0-4	12	16	28	1%
5-19	10	13	23	0%
20-34	40	18	58	1%
35-64	445	344	789	15%
65-74	520	365	885	16%
75-84	920	895	1815	34%
85+	591	1195	1786	33%
All ages	2538	2846	5384	

In 2006, 5,384 deaths were registered in Cumbria. Just over two-thirds of these deaths were in people aged over 75 years of age. The remainder died prematurely, losing 23,703 years of life, the equivalent of 316 people living to 75 years. As with differences in health across the districts, different areas also experience varying levels of mortality. Data released in June 2006 by The Office for National Statistics shows that someone living in Moss Bay ward, Allerdale had a life expectancy of 71.8 years whilst across in Eden's Greystoke ward, life expectancy was 91.3 years. Lifestyle contributes greatly to these discrepancies: Smoking, alcohol, diet, exercise, and an individual's attitude to life all play their part. County-wide analysis shows that Eden and South Lakeland are the healthiest districts in Cumbria.

Table 12: Cumbria and district mortality rates - Potential for saving life by health improvement, saving lives to age 75 years, 2006

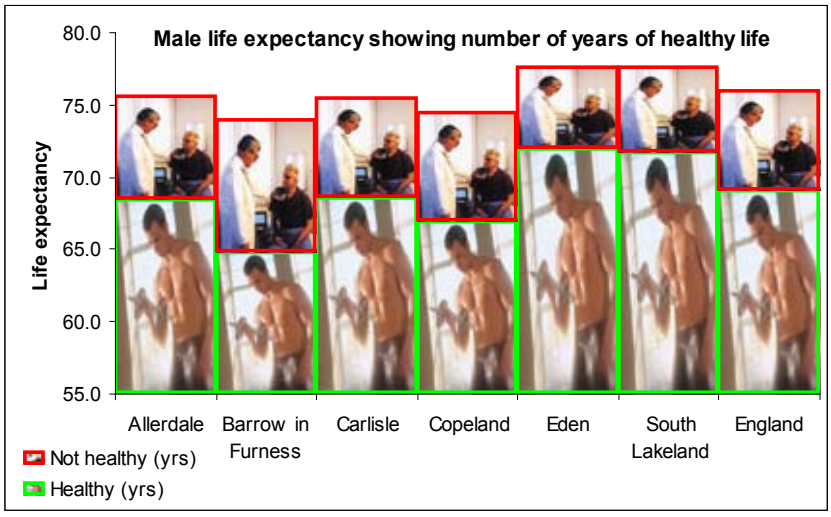
2006 mortality	Deaths <75	Lives saved	All deaths
Allerdale	377	80	1109
Barrow in Furness	285	76	779
Carlisle	390	101	1078
Copeland	275	83	718
Eden	135	1	500
South Lakeland	321	0	1200
Cumbria	1783	340	5384

It is an increasingly realistic aspiration that everybody should live beyond 75 years of good life. If every district in the county experienced the same levels of premature mortality as South Lakeland, 340 lives would be saved with Carlisle experiencing the greatest gain.

A priority for Cumbria is to find out more about why this is not possible for one-third of people and how we might change matters.

Of course we all want to live to a ripe old age – and - have the health to enjoy it. The definition of health used by the Office for National Statistics is "in good or fairly good self-perceived general health". By combining life expectancy with data on the health of a population it is possible to calculate the years of healthy life. Once again, across the county there are wide variations with men and women experiencing differing levels of health. Figures based on the last census show a man living in Barrow in Furness has an average life expectancy of 74 years: Of these he can expect to have 64.7 healthy years, with the remaining 13 percent of his life deemed unhealthy. His opposite number living in Eden can expect to live to 77.6 years with only seven percent unhealthy.

Figure 17: England and Cumbrian district male life expectancy showing years of health and unhealthy life

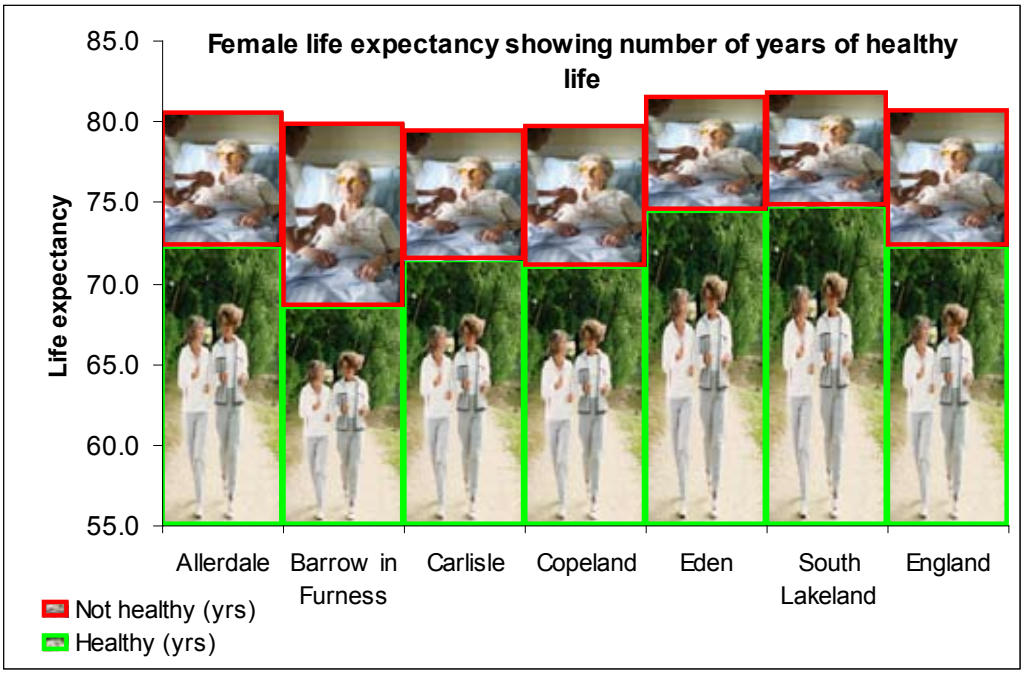


1902 The Registration of Midwives Act is passed

1902 1903

Cumbrian women live longer than their men: The average life expectancy for a woman living in Barrow-in-Furness is 79.9 years, and she can expect 68.5 years of healthy life with her remaining 11.4 years (14 percent) as unhealthy. Just across the council boundary in South Lakeland, female life expectancy is 81.8 years with 74.8 healthy years, the remaining 9 percent unhealthy.

Figure 18: England and Cumbrian district female life expectancy showing years of healthy and unhealthy life



Most Cumbrian babies enter the world in good shape – with only perhaps 1% having some initial problems requiring medical attention and most children will never see the inside of a hospital as a patient. One issue which is of some concern referenced in Table 13: Cumbria consultation rates in general practice, 2006 is the extent to which teenage and adult males are much less likely to have any routine contact with a general practitioner (GP) – only turning up once they are actually ill. Whilst women may have opportunities for preventative intervention when they are seen for family planning advice or with the children for their vaccinations, the same opportunities are not available by and large for men. Access to general practice has emerged as a significant political issue over the past year. We need to understand better whether the current patterns of contact and access are contributing to the much worse health experience of Cumbrian men.

Table 13: Cumbria consultation rates in general practice, 2006

	Males	Females	Ratio
Under 5 years	6.82	6.40	1
5-9 years	2.44	2.49	1
10-14 years	2.01	2.16	1
15-19 years	2.09	4.21	2
20-24 years	2.16	5.53	3
25-29 years	2.29	5.92	3
30-34 years	2.47	6.10	2
35-39 years	2.69	5.76	2
40-44 years	2.94	5.47	2
45-49 years	3.42	5.69	2
50-54 years	4.09	6.15	2
55-59 years	4.90	6.51	1
60-64 years	6.07	7.31	1
65-69 years	7.78	8.54	1
70-74 years	9.26	9.77	1
75-79 years	10.70	10.98	1
80-84 years	12.06	12.09	1
85-89 years	12.87	12.61	1
90+ years	11.65	11.77	1

Source: The Information Centre

Between April 2006 and March 2007, our residents accounted for 140,000 'first finished consultant episodes': A person is admitted to hospital and may be treated by one or more consultants under a different specialty, with each treatment during that stay in hospital being counted as an individual episode; therefore one spell in hospital may result in multiple episodes.

In Cumbria those aged between 20 and 54 years make up a third of all hospital admissions, and they stay for an average of 2.7 days. Those aged 55 and over, make up 56 percent of total episodes with an average length of stay of 5.4 days. If admitted to hospital you are likely to stay an average of 4 days in your first year of life. It is only when you reach your 70th birthday that an admission to hospital will exceed that initial stay of 4 days.

1906 The Liberal Government passed a number of public health and social welfare reforms which set a precedent for the National Health Service. These include the School Health Service with free school milk and school dinners

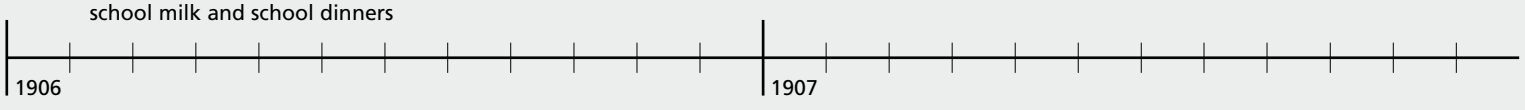


Table 14: Cumbrian hospital admissions by main diagnosis: Finished consultant episodes 2006-7 as numbers and percentages

Specialty	Under 55		Over 55		All ages
General Medicine	9596	*29%*	23574	*71%*	33170
General Surgery	8596	*40%*	13049	*60%*	21645
Trauma and Orthopaedics	5018	*43%*	6566	*57%*	11584
Obstetrics	8850	*100%*	0	*0%*	8850
Paediatrics	8848	*100%*	0	*0%*	8848
Urology	1495	*21%*	5648	*79%*	7143
Elderly Medicine	283	*4%*	6073	*96%*	6356
Gynaecology	4380	*78%*	1227	*22%*	5607
Ophthalmology	552	*10%*	4842	*90%*	5394
Ear Nose and Throat	2676	*69%*	1196	*31%*	3872
Other specialties	11171	*41%*	16163	*59%*	27334
All specialties	**61463**	***44%***	**78340**	***56%***	**139803**

On average 2,500 of our residents are discharged from hospital every week. During 2007/08 3,890 patients died in hospital that is between 70 and 80 each week. Almost one quarter of all admissions is under the specialty of General Medicine, with General Surgery accounting for 15 percent.

Figure 19: Cumbrians discharged from hospital, 2006-2007

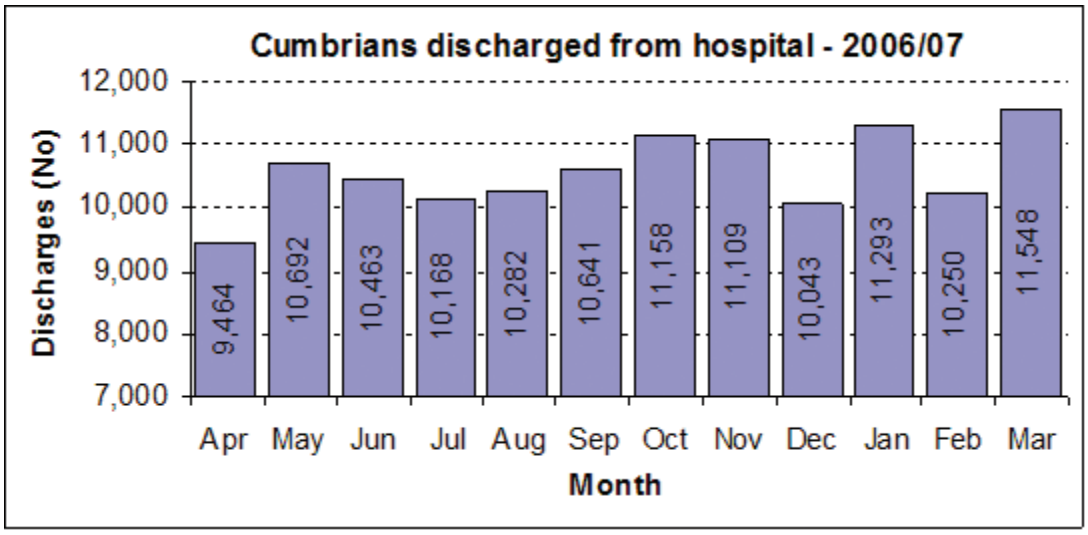


Table 15: Cumbria prevalence of dementia rates, 2006

Age Group	Prevalence Rates	People with dementia
65 to 69	1.4%	379
70 to 74	2.8%	647
75 to 79	5.6%	1,064
80 to 84	11.1%	1,532
85+	23.6%	2,832
Cumbria 65+	***6.8%***	***6,454***

Dementia Prevalence rates: Alzheimer's Society

As we age not only do we increasingly face physical problems, but our mental health may also deteriorate. Currently it is estimated there are 6,500 people aged over 65 years old in Cumbria suffering with some form of dementia. As the population continues to age, this number will rise dramatically and impact heavily on those services that care for these people. We need to plan now for how we will cope with up to 50% more people with dementia in the coming years if we are to care properly and avoid scandals.

Following the introduction of the new GP contract, a quality element was included as part of its criteria. This has led to the majority of NHS practices recording data relating to what conditions their patients present with. For the first time, Public Health has had access to population-based data on 17 disease areas or 'Registers'. Contained within these is information on smoking, adult obesity, cholesterol and blood pressure; important factors on the health agenda and essential to good Public Health.

Did You Know…?

16% of Cumbria's population are among the 20% most deprived groups in England.

1911 The Health Insurance Act is passed, setting up the first state medical insurance scheme in Britain for working men

1910-1918 A Stuart McTavish, Penrith Urban District Council
1910-1914 James MacDonald, Carlisle City Council
1910-1935 James Orr, Barrow Borough Council
1910-1914 J L Rankine, Longtown Rural District Council
1910-1931 F. H. Morrison, Cumberland County Council

1911-1939 William Henderson, Westmorland County Council

Table 16: Number of patients on Cumbrian GP practice disease registers at 31st March 2007

Practice Population	513,499
Hypertension	72,093
Obesity	39,553
Asthma	32,122
CHD	25,619
Diabetes	18,753
Thyroid	15,498
Chronic Kidney Disease	14,724
Stroke	11,164
COPD	9,642
Atrial Fibrillation	8,450
Heart Failure	5,446
Cancer	5,193
Mental Health	3,949
Epilepsy	3,368
Dementia	2,883
Learning Disability	1,801
Palliative Care	596

The data being generated from general practice under the Quality Outcome Framework (QOF) could be the beginning of a proper epidemiological intelligence system for planning a Closer To Home model of healthcare services based on public health considerations.

Although examples of health services based on knowledge of this kind do exist – from the work of Tudor-Hart in South Wales and Sydney Kark and his colleagues in Johannesburg and Jerusalem we have never had systematic primary and community care-based data to drive the NHS. At the moment it is early days and there are weaknesses in the data which is collected. However, there is an opportunity to develop the appropriate information systems in Cumbria in collaboration with the planned Cumbria Observatory!

Try as we may, we cannot go on forever. The Bible allotted us three score years and ten while the Government's White Paper "Saving Lives" would like us all to live to at least 75 years of age, but the one sure thing in life besides taxes is that we will all die. Ideally, we will have led a happy and fruitful life with few obstacles in our path. If we have succumbed to illness it is hoped that it has been late in life and did not impact too heavily on the quality of life. Above all, we are all entitled to a dignified death in a place of our choice. One in five deaths occur at home, while the vast majority of the remainder die in some type of institution, be it a hospital or nursing home.

In Cumbria 5,384 people died during 2006. The main cause of death is ischaemic heart disease, which accounts for one-in-five deaths. Strokes cause one-in-ten deaths with lung cancer being the third major cause accounting for one-in-sixteen deaths. Tobacco is incriminated in many of these deaths.

Figure 20: Major causes of death in Cumbria - all persons, all ages, 2006

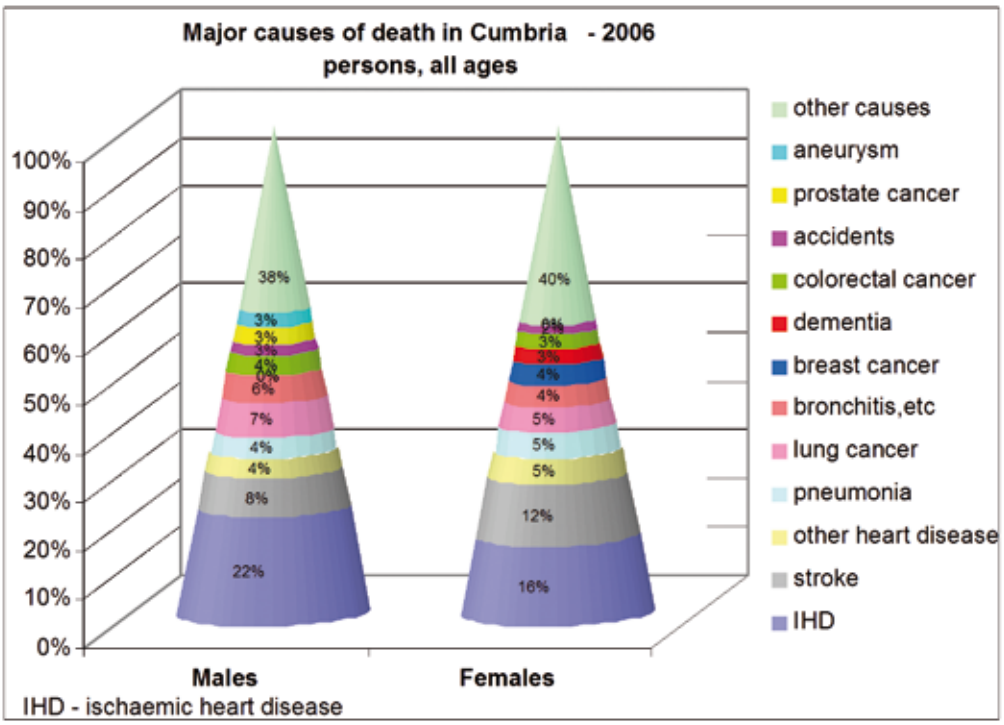


Table 17: Deaths in Cumbria by age, 2006

Age group	Number	% of all deaths
1	23	0%
1-4	5	0%
5-19	23	0%
20-34	58	1%
30-64	789	15%
65-74	885	16%
75-84	1815	34%
85+	1786	33%
All deaths	**5384**	

Very few deaths occur in the early part of life. In 2006 there were 68 deaths between the ages of 19 and 34 in Cumbria. Over 65 percent of these can be attributed to four major groups of causes:

- Motor vehicles – 14 deaths registered
- Suicides – 14 deaths registered
- Drugs – 7 deaths registered
- Accidents – 6 death registered

There were also three deaths as a direct result of alcohol consumption. These wasted lives are the tip of the iceberg of the damage caused to public health through alcohol and its role in injury and violence, mental distress and physical illness.

Section 7: Central Government and Local Priorities

In the 1970s, governments around the world began to move towards managerially-based models of health service performance, with the United States and Canada leading the way. These models were based on establishing central key targets together with appropriate indicators to measure progress. This approach was further promoted by the World Health Organisation in their strategy, "Health for All by the Year 2000" published in 1985, which led to the adoption of thirty-eight targets for the European region of the World Health Organisation:

Table 18: Focus of Targets for Health for All by the year 2000 in Europe

Targets 1-12: Health for All	
1	Equity in Health
2	Adding Years to life
3	Better opportunities for the disabled
4	Reducing disease and disability
5	Eliminating measles, polio, neonatal tetanus, congenital rubella, diphtheria, Congenital syphilis and indigenous malaria
6	Increased life expectancy at birth
7	Reduced infant mortality
8	Reduced maternal mortality
9	Combating disease of the circulation
10	Combating Cancer
11	Reducing Accidents
12	Stopping the increase in suicide
Targets 13 to 17: Lifestyles Conducive to Health for All	
13	Developing healthy public policies
14	Developing social support systems
15	Improving knowledge and motivation for healthy behaviour
16	Promoting positive health behaviour
17	Decreasing health damaging behaviour
Targets 18 to 25; Producing Healthy Environments	
18	Policies for healthy environment
19	Monitoring, assessment and control of environmental risks
20	Protecting against air pollution
21	Controlling water pollution
22	Improving food safety
23	Protecting against hazardous wastes
24	Improving housing conditions
25	Protecting against work-related health risks

Targets 26 to 31: Providing Appropriate Care	
26	A health care system based on primary health care
27	Distribution of resources according to need
28	Re-orientating primary medical care
29	Developing teamwork
30	Coordinating services
31	Ensuring quality of services

Targets 32 – 38: Support for Health Development	
32	Developing a research base for health for all
33	Implementing policies for health for all
34	Management and delivery of resources
35	Health information systems
36	Training and deployment of staff
37	Education of people in non-health sectors
38	Assessment of health technology

Whilst the targets from the World Health Organisation and those of the USA's Surgeon General both embraced public health, prevention and health care, until recently there has been very little real commitment in the United Kingdom to mainstream these Public Health objectives. In recent years, there has been increasing criticism of the target-driven approach and the untoward consequence of reducing the priority given to matters for which no target exists. So often the priorities of Health Ministers are historic and not driven by current intelligence. This has been described as driving a car looking in a rear-view mirror. Arguably, the way in which alcohol, obesity and sexually transmitted infections came from left-field to create public consternation are examples of this. The obsession with targets has been described as "hitting the target and missing the point", and a managerial technical approach to big issues affecting public health which are grounded in our culture, in commerce and how we live our daily lives has limitations. Public Health itself has been described as the political wing of medicine, and parliament as the pharmacy of public health. Clearly an integrated approach is needed which can take on board Sir Derek Wanless' "Fully Engaged Scenario", the essentially political nature of many health issues and at the same time optimise in a systematic way the capacity of health and social care services to make a difference.

What are the local Public Health targets?

Until recently, Cumbria had an increasing number of Public Health targets which must be achieved in collaboration with partner organisations. These targets are shown in Table 19 (The current Cumbria Public Health targets by policy initiative) below.

1918 An outbreak of Influenza pandemic results in the death of around 20 million people worldwide

1918

1919 H. W. Williams, Holme District Council
1919-1921 T S McIntosh, Whitehaven Rural District Council
1919-1925 W. Baron Cockhill, Windermere Urban District Council , South Westmorland Rural District Council, East Westmorland Rural District Council, Grasmere Urban District Council, Ambleside Urban District Council
1919-1946 W. Baron Cockhill, Appleby Borough Council

These targets are grouped together into categories (i.e. circulatory disease, cancer), and mapped to the appropriate policy initiative group. For example, the target for suicide is mentioned within all five policy initiatives.

Table 19: The current Cumbria Public Health targets by policy initiative

Area	Target	Initiative				
		Saving Lives Targets	Local Area Agreeement	Public Service Agreement	Local Delivery Plan	PCT Annual Health Check (New Standards)
Mortality	Reduce health inequalities - narrowing the gap in all age all cause mortality between England and the spearhead areas by 10% (Split into Male and Female)		Barrow and Carlisle			
	Reduce health inequalities - narrowing the gap in all age all cause mortality between England and the local authority areas		Allerdale, Copeland, Eden and South Lakeland	Cumbria, Barrow and Carlisle	Cumbria, Barrow and Carlisle	
	Reduce the gap between the 20% most deprived areas and the local authority overall rate within district		Allerdale, Barrow and Copeland			
Circulatory Disease	Reduce by 40% the mortality rate for persons aged under 75 Years	Cumbria and all six localities		Cumbria, Barrow and Carlisle	Cumbria, Barrow and Carlisle	Cumbria
	Reduce the premature mortality rate so that the gap between the national rate and the Local Authority is reduced		Allerdale, Barrow and Copeland			
Cancer	Reduce by 20% the mortality rate for persons aged under 75 Years	Cumbria and all six localities		Cumbria, Barrow and Carlisle	Cumbria, Barrow and Carlisle	Cumbria
Suicide and Undetermined Deaths	Reduce by 20% the mortality rate	Cumbria and all six localities	Cumbria and all six localities (Male / Female split)	Cumbria and all six localities	Cumbria and all six localities	Cumbria
Accidents	Reduce by 20% the mortality rate	Cumbria and all six localities				
Hospital Admissions from Serious Injury	Reduce by 10% the morbidity rate	Cumbria and all six localities				
Infant Mortality	Reduce Infant Mortality by 10% by 2010 between England and the most deprived areas (Monitored by Breastfeeding % and smoking during pregnancy)			Cumbria	Cumbria	Cumbria
Smoking	Decrease the prevalence of smoking (Monitored by the number of smoking 4 week quitters)		Cumbria	Cumbria	Cumbria	Cumbria
Obesity	Reduce the rate of Increase in Obesity (Childhood and Adults)		Cumbria	Cumbria	Cumbria	Cumbria
Teenage Pregnancy	Reduce Teenage Pregnancy by 50%		Cumbria and all six localities	Cumbria and all six localities	Cumbria and all six localities	Cumbria

Depending on which initiative they sit within, some areas may have more challenging targets, for example those assigned to the Spearhead areas of Barrow-in-Furness and Carlisle. The complexity of these particular targets will be discussed in more detail in

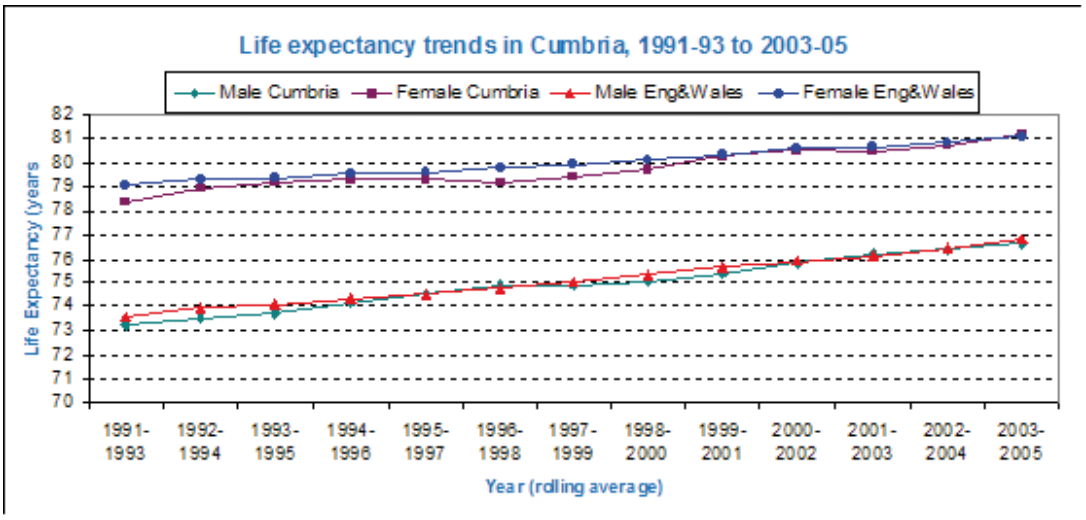
forthcoming locality health improvement work, to be published at a later date.
How we are doing against the main Public Health targets?

Locally, we must attain a wide range of targets. This section examines a selection of those targets showing how well Cumbria is performing against some of main Public Health priority areas.

Life Expectancy

In Cumbria, male life expectancy (2003-05) is slightly lower than that of England (see Figure 21: Life expectancy trends in Cumbria 1991-93 to 2003-05 below) - 76.6 years compared to 76.8 years for England. At district council level, life expectancy varies by 3.8 years; 78.6 years in South Lakeland and 74.8 years in Barrow. Female life expectancy is higher in Cumbria than England; 81.2 years compared to 81.1 years for England. Again at district level, there is a variation of 2.3 years; 82.7 years in South Lakeland compared to 80.4 years in Barrow.

Figure 21: Life expectancy trends in Cumbria 1991-93 to 2003-05

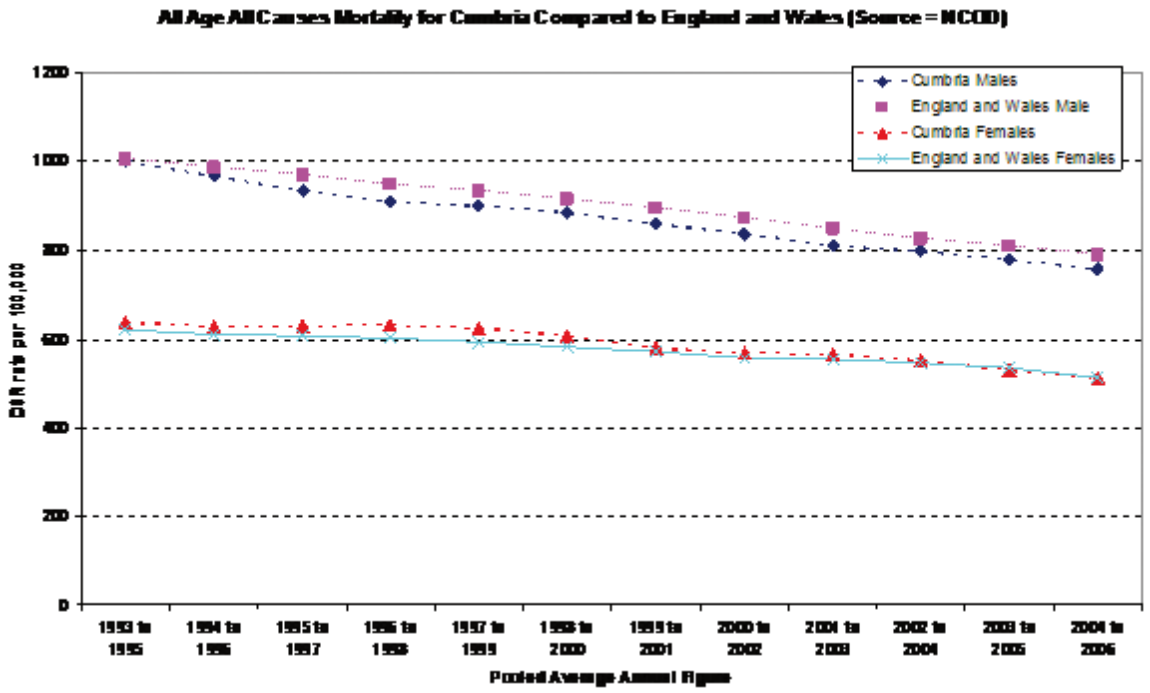


Between 1993-95 and 2003-05, the life expectancy gap between the best districts (Eden and South Lakeland) and the worst (Barrow) has widened. Therefore, the inequalities gap in life expectancy is widening within Cumbria itself.

Mortality

Although the Public Service Targets were set around life expectancy, the new Local Delivery Plan and Local Area Agreement targets have been defined under slightly different criteria, that of mortality rates. Latest figures show that overall male and female mortality rates are lower in Cumbria when compared with the national average as shown in figure 22 (Comparison of England & Wales with Cumbria of all age, all causes Mortality rates) below.

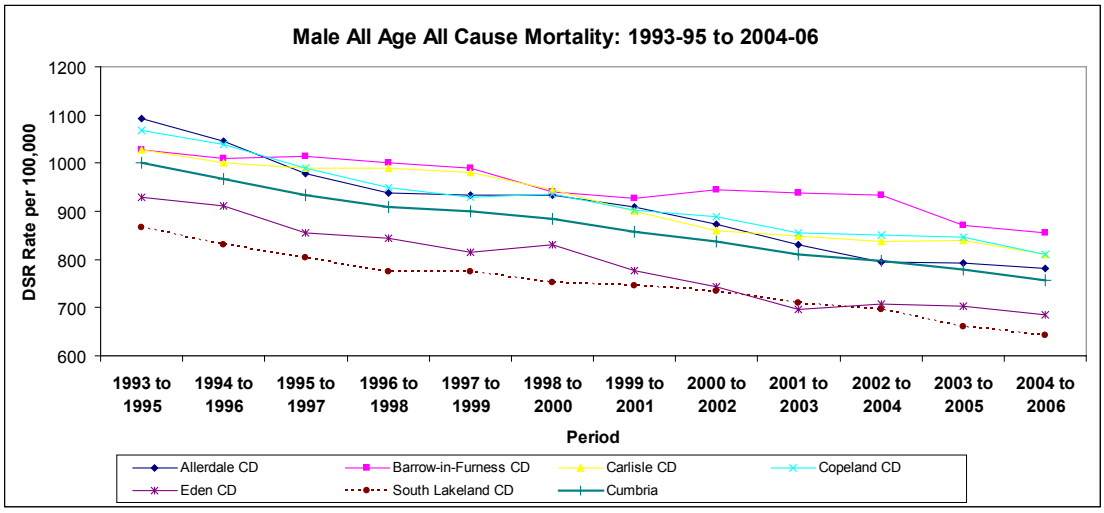
Figure 22: Comparison of England & Wales with Cumbria of all age, all causes Mortality rates



Male Mortality

Large differences in male mortality are found within the Cumbria's six districts. In the spearhead areas of Barrow and Carlisle, mortality rates are 856 and 811 per 100,000 of the population compared to 643 per 100,000 in South Lakeland. The figure below shows the inequalities in mortality in the county.

Figure 23: Cumbria and districts male all age, all cause Mortality, 1993-95 to 2004-06

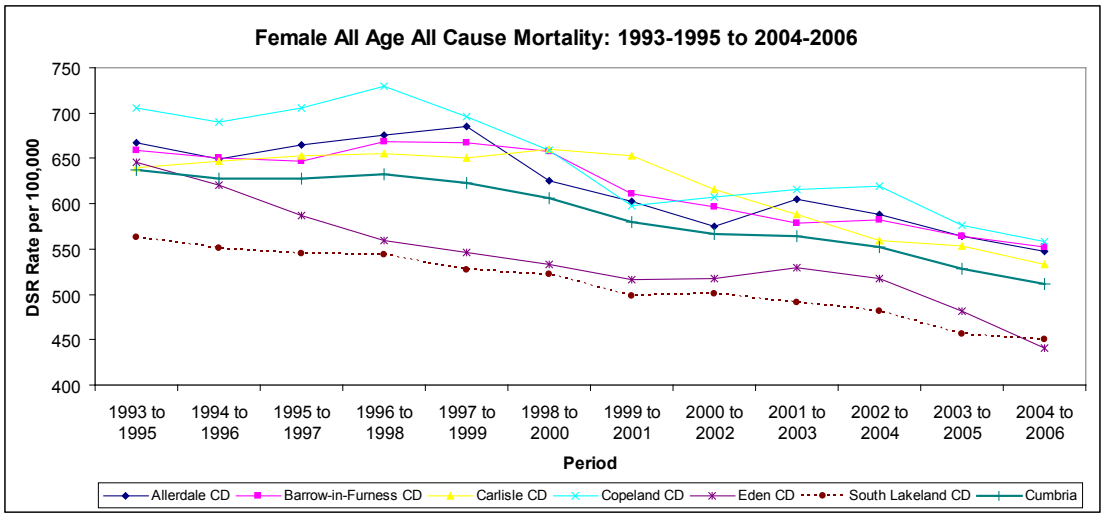


The gap in mortality between the Local Authorities appears to be changing. For example, rates in Copeland have currently fallen by 8.9% from baseline (1997-1999) compared to 15.0% in Allerdale. The data shows that based on current trends, Barrow is not likely to reach its Local Area Agreement target of 769 male deaths per 100,000 of the population. However, it looks likely that Carlisle will meet its target of 719 male deaths.

Female Mortality

Once again, variations can be found in female mortality levels. Barrow and Carlisle experience mortality rates of 552 and 534 per 100,000 populations compared to 441 per 100,000 in Eden. The graph below shows the inequalities between the council areas of Cumbria.

Figure 24: Cumbria and district female all age, all cause mortality, 1993-95 to 2004-06

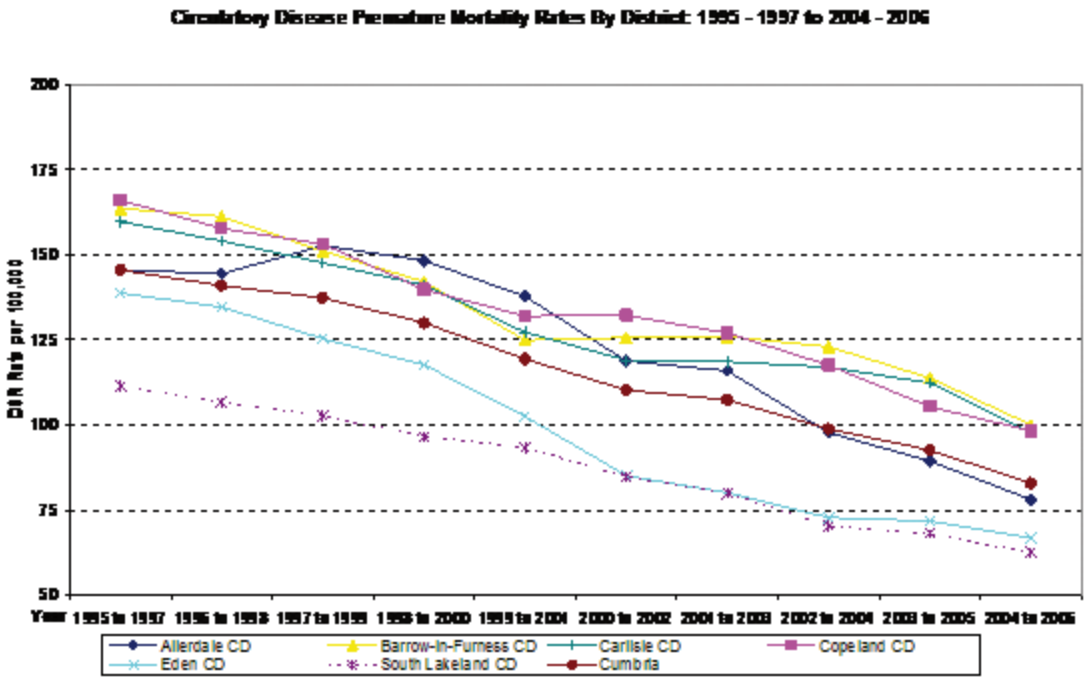


The gap in female mortality between districts also appears to be changing. The mortality rate has fallen by 14.4% in South Lakeland from baseline (1997-1999) compared to 20.1% in Allerdale for the same period. With regards to the Spearhead areas, data shows that both Barrow and Carlisle are likely to reach their Local Area Agreement target rate of 503 and 507 per 100,000 based on current trends.

Premature Mortality – Circulatory Diseases

In Cumbria, the premature mortality rate from circulatory diseases - mainly stroke and heart disease – are almost 74 deaths per 100,000, making it less than the England average of 84.7 deaths (2005 data). Locally, our Spearhead areas have higher rates, with Barrow losing 100 per 100,000 and Carlisle 98 per 100,000 of the population. South Lakeland has the lowest rate of 62 per 100,000. Trend data is shown below in figure 25 (Cumbria & Districts Circulatory Disease Premature Mortality Rates, 1995-97 to 2004-06).

Figure 25: Cumbria & Districts Circulatory Disease Premature Mortality Rates, 1995-97 to 2004-06



Our county currently has a lower premature mortality rate for circulatory disease than the national average. If this trend continues, we will reach our target reduction of 40% by 2010 and rates will be below those of England and Wales. For the two Spearhead areas, rates have fallen by 39% from the baseline (1995-1997) and will definitely both achieve their target.

Premature Mortality – Cancer

In Cumbria, premature mortality rates from cancer are nearly 120 deaths per 100,000 of the population; slightly higher than the national average of 119 (2005 data). Again the Spearhead areas have the higher rates; Barrow with 146 per 100,000, and Carlisle with 130 per 100,000. Eden has the lowest rate at 93 premature deaths to cancer per 100,000 of the population. Premature mortality trends from cancer are shown in the figure below.

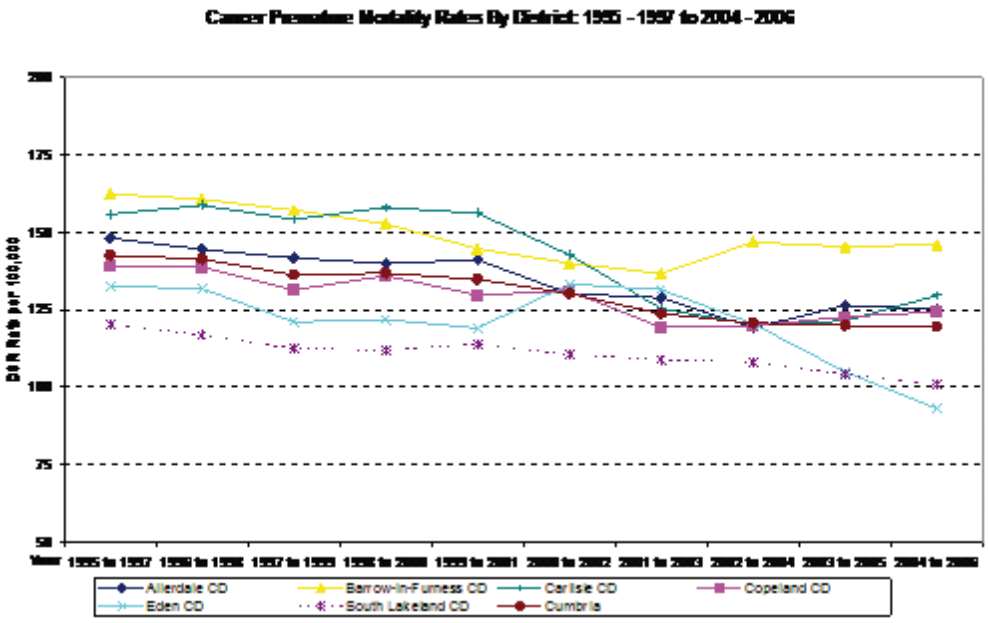
Did You Know…?

During 2006, the lowest unemployment rate in Great Britain was in Eden, Cumbria at 2%, compared to 14% at Tower Hamlets, London and 10% in South Tyneside.

1928 Penicillin is discovered by Alexander Fleming

1928 1929

Figure 26: Cumbria and Districts Cancer Mortality rates, 1995-97 to 2004-06



Cumbria's levels for premature deaths for cancer are slightly higher than the national average. If the county's current trend continues, we will reach the 2010 target.

Infant Mortality

Whilst infant mortality was discussed in the previous chapter, research shows that certain risk factors - smoking during pregnancy, giving birth to a low birth weight baby and not breastfeeding your baby during their first few months of life - mean that an infant suffers a greater chance of dying. Cumbria Primary Care Trust is beginning to closely monitor these three factors in their efforts to reduce mortality in early years and improve life expectancy overall.

Smoking

The main target here is to reduce adult smoking rates (from 26% in 2002) to 21% or less by the year 2010. Also stipulated is to reduce smoking prevalence among routine and manual groups from 31% in 2002 to 26% or less. This socio-economic group is too small to measure, so the 4-week smoking 'Quitter' rate is used as a substitute for this target Latest data shows that the 4-week quit rate per 100,000 of the population is gradually increasing. However, in this current period only 928 people have successfully quit at 4 weeks instead of the Local Delivery Plan target of 1788 by September 2007. Cumbria Primary Care Trust is implementing an action plan to achieve this target by the end of March 2008.

An estimated 25% of Cumbrian adults smoke compared with 26% for England. Carlisle has the highest estimated prevalence of smokers (29.3%) while the lowest is

in South Lakeland (22.3%). There are wide variations at ward level with estimates ranging from 11.9% to 46.5% across the county. Prevalence is markedly higher in manual working groups (29%) contrasting with 19% of non-manual workers who smoke.

In Cumbria, an average of over 900 people die each year as a result of smoking-related conditions. This equates to 17 percent of all deaths within the Primary Care Trust area, just below the national figure of 18 percent. On a district level, Allerdale and Carlisle have the highest number of smoking-attributable deaths with around 1 in 5 or 20 percent. For deaths in men aged 35 and over, a larger proportion is attributable to smoking with an estimated 22 percent, rising to 24 percent in Allerdale and Carlisle and representing almost one quarter of all deaths. Women fare better with 13 percent of all deaths due to smoking and again Allerdale and Carlisle have slightly higher levels at 14 percent.

Obesity

Another key target is to tackle the underlying causes of ill health and health inequalities by halting the year-on-year rise in child obesity. In order to help address this issue, the Department of Health has introduced a national scheme to weigh and measure the heights of reception age (4-5 year olds) and Year 6 (10-11 year olds) school children.

The results of the audit show that in England 23% of reception age children were recorded as being overweight (12.9%) or obese (9.9%). West Cumbria appears to have higher levels of overweight (13.8%) and obese (11.5%) children compared to the England average as shown in the table below.

Did You Know…?

Of the 2.4 million Incapacity Benefit claimants in the UK, Barrow-in-Furness accounts for 5,600, equating to around 7%, or 1 in 14 of all working age adults.

Table 20: Overweight and Obesity in Cumbria and Districts, 2005-6

FORMER PCTs	Number of Pupils Measured	Overweight Numbers	Overweight Percentage	Obese Numbers	Obese Percentage
Carlisle & District	**624**	77	*12.3*	73	*11.7*
Eden Valley	**429**	43	*10.0*	46	*10.7*
West Cumbria	**858**	118	*13.8*	99	*11.5*
South Cumbria	**1,621**	214	*13.2*	133	*8.2*
Cumbria PCT	**3,532**	452	*12.8*	351	*9.9*

N.B. Barrow-in-Furness data is incorporated into South Cumbria statistics.

By year 6, the proportion of pupils who were overweight or obese in England was 31%. Data for Cumbria Primary Care Trust is not available for this particular age group due to initial difficulties with data collection. The county child heights and weights data for 2006/07 has been submitted to the Information Centre and is currently being validated. A report will be released later in 2008 by the Information Centre to examine current progress in Cumbria compared to England.

Data from the Quality and Outcomes Framework shows that obesity levels in Cumbria Primary Care Trust GP practices is roughly about 7.7% compared to 7.2% for England. Obesity data for the six districts highlights a huge variation in the obesity rate from 9.4% in Allerdale to 5.8% in South Lakeland.

Sexual Health

The National Teenage Pregnancy Strategy is to halve the under 18 conception rate in England by 2010.

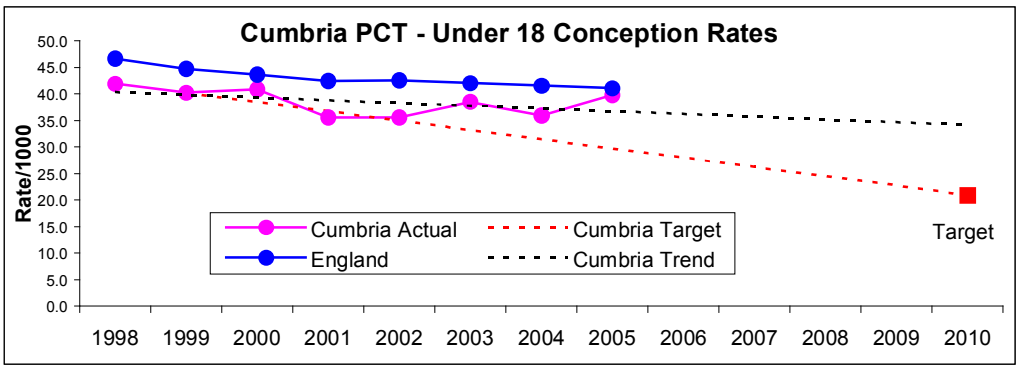
Cumbria Primary Care Trust's baseline conception rate was 42 conceptions per 1000 girls aged 15 to 17 years (362 conceptions), so a reduction of 50 percent would result in a rate of: 21 per 1000 (181 conceptions).

Latest figures for 2005 show the rate in Cumbria as 39.8 conceptions per 1,000 girls, just below the England rate of 41.1. Current rates are relatively high in Copeland (61.1), Barrow (51) and Carlisle (50.3), while Eden, South Lakeland and Allerdale rates are all below the England average.

The reduction in the Cumbria rate between the 1998 baseline and 2005 is 5% compared to a national reduction of 11.9%. Eden has seen the greatest reduction

(47.7%) followed by South Lakeland (34.9%), whilst significant increases occurred in Carlisle (22.8%) and Copeland (18.7%). The chart below shows that both nationally and locally the planned 50% reduction by 2010 is not currently on track to be met. In fact, the teenage pregnancy rate is actually starting to increase in Cumbria (2005).

Figure 27: Cumbria Primary Care Trust Under-18s Conception Rates per 1,000 of the population



The number of newly diagnosed cases of Sexually Transmitted Infections detected at Genito-urinary Medicine Clinics in Cumbria hospitals during 2006 are listed below:

- Chlamydia -1554 new cases,
- Gonorrhoea - 133 new cases,
- Herpes - 137 new cases,
- Genital warts - 1303 new cases.

These figures do not include cases diagnosed through other sources such as GP practices. Cumbria Primary Care Trust will have to monitor the number of patients diagnosed with gonorrhoea under the Annual Health check. The long term aim of the Trust is to see a reduction in the number of new Gonorrhoea Cases.

Cumbria Primary Care Trust has started to screen high risk age groups (15 to 24 years of age) for Chlamydia. The Local Delivery Plan target is that 5% - or 3492 people - of this age group will be screened or tested for Chlamydia by the end of March 2008 and the Trust is actively working towards this target. As with other new screening programmes, the roll-out period is expected to show an increased number of new Chlamydia cases in the short term.

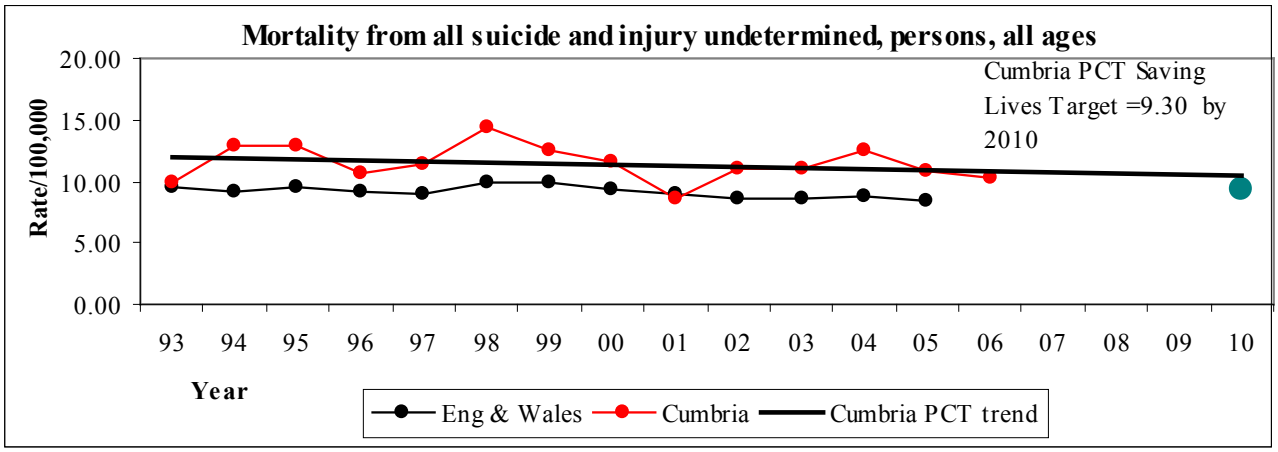
In recent years, access to genito-urinary medicine clinics in some parts of Cumbria has been a problem. The recent opening of the Birchwood clinic in Barrow is beginning to make an impact on this issue and we are currently working with clinical staff in the rest of the county to develop more accessible service times, particularly in the evenings and on Saturdays. The goal is to ensure more consistent sexual health service

provision county-wide in order to meet a recently introduced target of enabling people to access sexual health services within 48-hours of identified need.

Mental Health and Well Being

The latest 2006 figures show that Cumbria's mortality rate for suicide and undetermined injury is 11.4 per 100,000; markedly above the national average of 8.6 per 100,000 for 2003 to 2005. The suicide rates in our Spearhead areas are higher still than the England average with-Carlisle 14.5 per 100,000 and Barrow 13.1 per 100,000. The lowest rate is in Copeland at 9.4 per 100,000.

Figure 28: England & Wales, Cumbria and Cumbria Primary Care Trust Trend in mortality from all suicide and undetermined injury, all persons, all ages, 1993-2010



The Public Service Agreement target is to reduce mortality rates from suicide and undetermined injury by at least 20% no later than 2010 (taken from the 'Our Healthier Nation' baseline targets, 1995 - 1997). The chart above shows that Cumbria Primary Care Trust may miss this 2010 target, due to higher rates in some districts: From the baseline period (1995-1997), suicide rates have increased by 21% in Barrow, 18% in South Lakeland and 16% in Copeland when compared with figures for 2003-2005. Although the numbers involved are quite small and random fluctuations can be quite misleading, this situation is a cause for concern which needs to be addressed.

Drivers for Change - The new NHS Operating Framework (2008/09) and Local Area Agreements

The core principles of "Health for All" are still regarded as important, as seen by their inclusion in the new NHS Operating Framework for 2008/09. This document is starting to move NHS policy away from a top-down, target setting approach to more autonomous assessment with our Local Authority partners (through the Local Area Agreement process). Central Government is introducing a new nationally integrated

set of targets and indicators which will be jointly owned by the Primary Care Trust and main local partners. Therefore, instead of having five main initiatives (Saving Lives, the Local Area Agreement, Public Service Agreement, Local Delivery Plan and PCT Annual Health Check) with their own individual targets, we are moving towards having just two core groups of outcome-based targets (the Local Area Agreements and Local Delivery Plan). These changes are described in more detail below.

In the **NHS Operating Framework** there will be three sub-sections of vital signs or indicators (see image below).

Firstly, there are **National Priorities** – these are "must do's" for the Primary Care Trust, listed below:

- Improve Cleanliness and reduce the number of Health Care Acquired Infections
- Improve access through achievement of the 18 week referral treatment pledge, • and improve access to GP surgeries
- Keep adults and children well, improve health and reducing health inequalities
- Improve patient experience, staff satisfaction and engagement
- Prepare to respond to a state of emergency, such as an outbreak of pandemic 'flu.

Secondly, there are issues that are of national concern that Primary Care Trusts must tackle locally through consultation with patients, public and staff, Joint Strategic Needs Assessment and in agreement with partners. These service areas are listed below:

- Provision of mixed sex accommodation
- Learning disabilities care
- Diabetic retinopathy
- Crisis resolution capacity
- Improved access to psychological therapies

- Facilities for older people with dementia
- End of life care
- Services for disabled children

Thirdly, there are Local Priorities based on needs identified through the Cumbria Joint Strategic Needs Assessment project with community engagement. Greater autonomy will enable Cumbria Primary Care Trust and local partners to move towards tackling more local and county-wide priorities, and the development of more local outcomes indicators to track progress.

A new National Indicator set for the Local Area Agreement

For the first time, the Department of Communities and Local government is consulting on having a single unified set of 198 national indicators. It is intended that the indicators will:

a) Be the only measures on which central Government will performance-manage outcomes delivered by local government, either working alone or in partnership;
b) Replace all other existing sets of indicators including Best Value Performance Indicators and Performance Assessment Framework indicators;
c) Be published annually by all areas from April 2008.

This change will enable a local population to understand how well or poorly their Primary Care Trust is performing and ensure better accountability to the local population.

In each area, targets will be set against these national indicators and will be negotiated through revised Local Area Agreements (LAAs). Each Agreement will include up to 35 targets chosen from the national indicators and be complemented by statutory targets on educational attainment and early years.

"Levelling Up" Versus "Closing the Gap"

Recent government policy within the area of health inequalities has concentrated on trying to "**close the gap**" between populations with poor health outcomes and those with good health. For example, some of the current targets are related to reducing the gap in life expectancy between the worst 20% of Local Authorities (i.e. Spearhead areas like Barrow and Carlisle) and the population as a whole. Another method of tackling inequalities is called "Levelling Up" and is discussed in detail in a document produced by the World Health Organisation called "European Strategies for Tackling Social Inequities in Health".

The concept of "Levelling Up" means that we should improve the health outcomes of the worst areas of Cumbria up to the levels of the best areas of Cumbria. Potentially this approach can then be used again to compare the county to the North West

region, or even to England as a whole. For example, in terms of life expectancy we should try to improve the life expectancy of residents in Moss Bay, Allerdale from 71.8 years to the 93 years experienced by the residents of Greystoke ward in Eden. Regardless of which method is used by the Primary Care Trust and its local partners - whether it be "Levelling Up" or "Closing the Gap" - they need to use the best available evidence and best practice within the commissioning process to tackle these inequalities in measurable health outcomes. How Levelling Up can be utilised in Cumbria to address inequalities is discussed in more detail in Chapter 9.

Did You Know...?

Police-recorded crime in Cumbria fell by 10% in 2006-7 compared with a 2% drop for England and Wales.

1944-1945 James C B Craig, Carlisle City Council

1945-1947 James Lamberton, Carlisle City Council

Section 8: Levelling Up - Social Justice and Health in Cumbria

Despite unprecedented increases in standards of living across Cumbria as also seen throughout the UK, these benefits have not been experienced equally across the population. In particular, the life expectancy varies by almost 20 years between the best and worst electoral ward areas in Cumbria. Certain groups of people also tend to suffer from worst health outcomes as a result of inequalities in income, education or staff group. Michael Marmot's book, "the Solid Facts on Inequalities"[13] identifies ten areas which potentially have a significant effect on inequalities in a population such as Cumbria. These priority areas for action are listed below:-

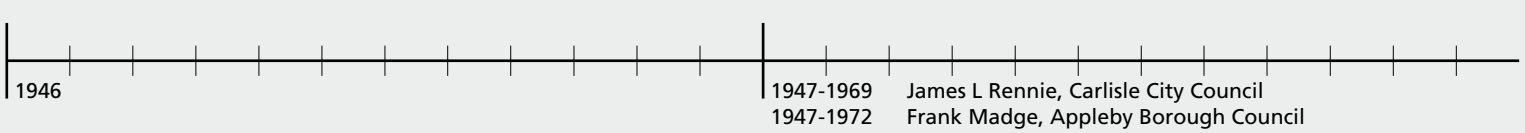
1 The need for policies to prevent people from falling into long term disadvantage
2 How the social and psychological environment affects health
3 The importance of ensuring a good environment in early childhood
4 The impact of work on health
5 The problems of unemployment and job insecurity
6 The role of friendship and social cohesion
7 The dangers of social exclusion
8 The effects of alcohol and other drugs
9 The need to ensure access to supplies of healthy food for everyone
10 The need for healthier transport systems

The focus of the World Health Organisation is on focussing upstream on the 'determinants of the determinants of health'.

Disappointingly, attainment of certain national and local targets is unlikely for our county. Based on current trends, Cumbria is unlikely to achieve the set targets for suicide, teenage pregnancy and smoking quitters, while the actions on childhood obesity are at too early a stage to tell whether the increasing trend in obesity will level off. In order to make a better assessment of this issue, Cumbria Primary Care Trust is trying to improve the quality of childhood obesity baseline data.

While all six county districts show better performance, the best districts - Eden and South Lakeland - are improving at a much quicker rate. As a result, the gap between the best performing districts and the two spearhead areas - Carlisle and Barrow - appears to be widening for many of these indicators, as seen with life expectancy for instance. In particular, the premature cancer mortality rate for Barrow men is starting to stagnate.

"Where Health Means Wealth," a report produced by the North West Public Health Observatory, also identifies contrasting levels in life expectancy and health outcomes between areas of deprivation and more affluent areas. In particular, this report



found that the differences observed across the North West were most pronounced in levels of self harm, violence, chronic obstructive pulmonary disease, alcohol related conditions, births to lone mothers and the numbers of those claiming Disability Living Allowance and Incapacity Benefit.

A more tangible method of expressing how we can address these differences is an approach called "levelling up", in which numbers indicate how many more (or less) cases would make the difference in health levels for defined groups of the population. To apply this approach to Cumbria, the comparison would be of our six districts against each other and is detailed below.

All Age Mortality (Number of deaths)

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

Table 21: Cumbria and District All Age, All Cause Mortality, Best Case Scenario, 2004-2006

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

Source = NCOD (2007)

Deaths from Circulatory Disease in the Under 75s

Within Cumbria if the best circulatory disease mortality rate in South Lakeland (62 per 100,000 populations under 75 years of age) was applied to each district, we would expect to reduce the number of premature deaths from circulatory disease by 386 over a three year period or 129 each year (2004 to 2006). The data is shown in more detail in the table below.

1948 The World Health Organization (WHO) was established by the United Nations on April 7
The National Health Service comes into operation, launched by Health Secretary Aneurin Bevan on July 5 at Trafford General Hospital, Manchester

1948-1951 G. G. Dickie, Barrow Borough Council

1949

Table 22: Cumbria and Districts Premature Deaths from Circulatory Disease, Best Case Scenario, 2004-2006

Area	Best case	
	Estimated Circulatory Disease Deaths	Decrease from current numbers
Allerdale	225	58
Barrow-in-Furness	156	94
Carlisle	225	130
Copeland	160	94
Eden	129	10
South Lakeland	271	0
Cumbria	1166	386

Source = NCOD (2007)

Deaths from Cancer in the Under 75s

Within Cumbria if the best cancer mortality rate in Eden (94 per 100,000 populations under 75 years of age) was applied to each district, we would expect to reduce the number of premature deaths from cancer by 487 over a three year period or 163 each year (2004 to 2006). The data is shown in more detail in the table below.

Table 23: Cumbria and Districts Premature Deaths from Cancer, Best Case Scenario, 2004-2006

Area	Best case	
	Estimated Premature Cancer Deaths	Decrease from current numbers
Allerdale	337	116
Barrow-in-Furness	234	129
Carlisle	342	134
Copeland	238	79
Eden	192	0
South Lakeland	398	29
Cumbria	1741	487

Source = NCOD (2007)

Infant Deaths (Under 1 Year)

Within Cumbria if the best infant mortality rate in Copeland (3.2 per 1000 live births) was applied to each district, we would expect to reduce the number of infant deaths by 20 over a three year period (2004 to 2006). The data is shown in more detail in the table below.

Table 24: Cumbria and Districts Infant Mortality, Best Case Scenario, 2004-2006

Area	Best case	
	Estimated Infant Deaths	Decrease from current numbers
Allerdale	9	4
Barrow-in-Furness	7	3
Carlisle	11	5
Copeland	7	0
Eden	5	2
South Lakeland	8	6
Cumbria	47	20

Source = NCOD (2007)

Suicide and undetermined deaths

Within Cumbria if the best suicide rate in South Lakeland (9.5 per 100,000) was applied to each district, we would expect to reduce the number of suicides by 8 averaged over a year (pooled period 2003 to 2005). The data is shown in more detail in the table below.

Table 25: Cumbria and Districts Suicides and Undetermined Deaths, Best Case Scenario, 2003-2005

Area	Best Case	
	Estimated Suicides	Decrease from current numbers
Allerdale	9	0
Barrow-in-Furness	7	-2
Carlisle	10	-5
Copeland	7	0
Eden	5	-1
South Lakeland	10	0
Cumbria	48	-8

Source = NCOD (2007)

1952 The first polio vaccine is developed by Jonas Salk

1952-1976 Frank Madge, Combined County Districts of Westmorland 1953

Teenage Pregnancy

Within Cumbria if the best teenage pregnancy rate in South Lakeland (20.8 per 1000 females aged 15 to 17 year) was applied to each district, we would expect to reduce the number of teenage conceptions by 480 over a three year period (2003 to 2005). The Primary Care Trust would also have reached the 2010 target of reducing by 50% the teenage conception rate to 21 per 1000. The data is shown in more detail in the table below.

Table 26: Cumbria and Districts Teenage Conceptions, Best Case Scenario, 2003-2005

Area	Best case	
	Estimated Conceptions	Decrease from current numbers
Allerdale	108	-86
Barrow-in-Furness	91	-113
Carlisle	117	-177
Copeland	87	-102
Eden	55	-1
South Lakeland	120	0
Cumbria	577	-480

Source = NCOD (2007)

Adult Obesity (Body Mass Index >30)

Within Cumbria if the best adult obesity rate in South Lakeland (5.8%) was applied to each district, we would expect to reduce the number of obese adults by 9,916. . The data is shown in more detail in the table below.

Table 27: Cumbria and Districts Adult Obesity, Best Case Scenario, 2006-2007

Area	Best case	
	Estimated Obese Adults	Decrease from current numbers
Allerdale	5748	3609
Barrow-in-Furness	4957	1389
Carlisle	6113	2316
Copeland	3624	2414
Eden	2951	188
South Lakeland	6244	0
Cumbria	29637	9916

Source = QMAS (2007)

The principle of levelling up can also be used to compare Cumbria with our best regional Local Authority areas and primary care trusts, or even compare with the best performing healthcare organisations nationally and internationally. This useful concept will be developed further by the Primary Care Trust Intelligence function to a much wider range of health indicators in future annual reports and publications.

1954 Sir Richard Doll establishes a clear link between smoking and cancer

1954

1955-1956 Alex S. Smith, Ennerdale Rural District Council
1955-1959 W.H.P. Minto, Cumberland County Council

Section 9: The Arrangements for Public Health in Cumbria

Public Health Defined:

Public Health works to improve health across communities using a three tiered approach:

- To raise levels of wellbeing across the whole population.
- To address specific, known issues affecting groups within the population who are most at risk of poor health, or whose health is threatened by particular risk factors or risk conditions.
- To ensure that the health needs of those who are already ill, such as those with heart disease or mental health problems are equitably met by evidence-based, high-quality personal Health and Social Services.

In his 1988 report on Public Health in England[14], Sir Donald Acheson drew upon Winslow's definition of Public Health to frame the task: "Public Health is the science and art of preventing disease, prolonging life and promoting physical health and efficiency through organised community efforts for the sanitation of the environment, the control of community infections, the education of the individual in principles of personal hygiene, the organisation of medical and nursing service for the early diagnosis and preventative treatment of disease, and the development of a social machinery which will ensure to every individual in the community a standard of living adequate for the maintenance of health".

The importance of this definition is in making explicit that health and social care are but one part of the system for Public Health. Who our parents are, where we were born, lived, grew up and went to school, the culture around us and the social and psychological influences we experience, our economic opportunities to live the good life and the physical environment that impacts upon us – both natural and manmade – all converge to shape our health chances. In turn, our experience of health enables us to influence those things to a greater or lesser extent. The task is to create conditions in which we can thrive as humans in the same way that plants or livestock thrive and at the same time to ensure that the application of science and evidence-based knowledge through personal services can make the most appropriate and optimal contribution to our welfare.

In Cumbria, the commitment to develop whole system working between health services, Local Authorities and many significant others with devolution to neighbourhood and community means that there is a real opportunity to craft a public health system fit for modern times. Among the most significant changes

have been the unification of the Cumbrian part of Morecambe Bay together with the North Cumbrian Primary Care Trusts into a single organisation. This new trust has undertaken a comprehensive planning and restructuring aimed at building strong, strategic links at county level, devolving services from county to localities in partnership with other agencies and local people and transforming itself into an organisation of partnership and commissioning built on a public health understanding of health and its determinants.

For the first time since 1974, Cumbria has public health leadership which is firmly rooted in its Local Authorities, as well as its National Health Service with the creation of the post of Director of Public Health who also happens to be County Medical Officer.

The Public Health Directorate

The Public Health Directorate incorporates several functions. The basics of public health action lies in good intelligence to inform Health Improvement, Health Protection, specific population-based prevention programmes, Public Health Commissioning and Partnership Working. Highly developed Communications and evidence-based supportive materials are essential to all the effective delivery of all these strands.

A multi-disciplinary team split between different districts across the county, Public Health colleagues work from locality bases in Barrow, Carlisle, Kendal and Workington and enables an accurate understanding of, and insight into, local community issues.

The team also benefits from long established relationships with key partner agencies, including many district-based organisations and councils, the Local and County Strategic Partnerships and Cumbria County Council.

As evidence-based working is core to the Directorate's strategic planning responsibilities, reliable intelligence is necessary to inform the direction of new initiatives and their implementation. One major provider of information is the North West Public Health Observatory, which is working closely with the Primary Care Trust's own Intelligence Team, and supporting the development of the integrated Observatory for Cumbria.

Arrangements

The structure of the Public Health Directorate in Cumbria Primary Care Trust allows for engagement with the specific community and organisational structures that are present within each of Cumbria's six local government areas. Two Associate Directors, and locality health improvement teams, lead the development of locality working

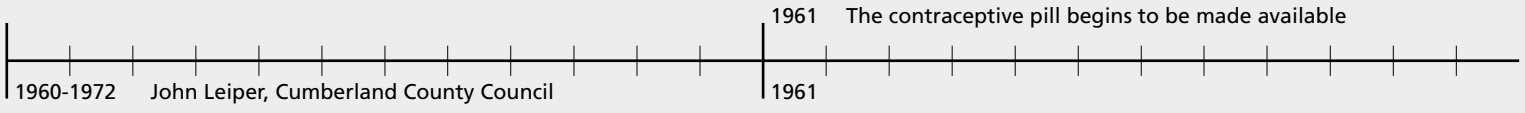
across North and South Cumbria, with each "patch" covering three local government districts: Allerdale, Carlisle and Copeland in the North; Barrow, Eden and South Lakeland in the South. The Associate Directors also work closely with the local GP clinical leads, in developing health improvement strategies to meet local needs.

At district / borough level, Local Strategic Partnerships have been established as a means of planning and coordinating action across a range of agencies to improve health. In South Cumbria, the three districts of Barrow, Eden and South Lakeland each have very different patterns of health and – in response to this – different priorities for health improvement action have been developed. Barrow has a strong partnership infrastructure which has developed, because of its high deprivation levels. Local planning for health improvement is coordinated by a sub-group of the Furness Partnership. The focus for health improvement in this locality is on improving performance on key health targets, such as life expectancy (particularly for men), reducing the number of teenage pregnancies and reducing suicide and accident rates.

Improving life expectancy of men in Barrow is a significant challenge, but is an important one if we are to reduce health inequalities in the county. A priority focus will be on the most deprived wards where life expectancy is several years below the national average. The Health Improvement Plan for Barrow sets out a number of key action areas which will be delivered in partnership with other agencies such as Job Centre Plus, Sure Start, Barrow Borough Council and the Neighbourhood Management Teams. The identification and support of people at greater risk of developing health problems such as coronary heart disease will also be a focus of new innovative community-based programmes, linked to GP services. There will also be an emphasis on working with partner agencies to give people more intensive support in making lifestyle changes that will improve their health. A major focus will be on helping people to stop smoking.

Eden and South Lakeland have developed strong Local Strategic Partnerships. Both districts cover large rural areas with widely dispersed populations. They face similar issues in meeting the needs of their ageing populations, improving the availability of affordable housing, sustaining viable communities, developing local jobs and educational opportunities and ensuring access to services for widely dispersed communities. Although these districts appear relatively affluent with comparatively good overall health indicators, there are problems with poverty and social isolation among some individuals and groups. Priorities for improving health include smoking cessation, reducing alcohol misuse and improving access to health services.

Carlisle has a long history that has shaped the city today, but it is a city looking to the future. Despite devastating events such as 2001's foot and mouth outbreak and the floods of 2005, the communities and partnerships that make up Carlisle and District



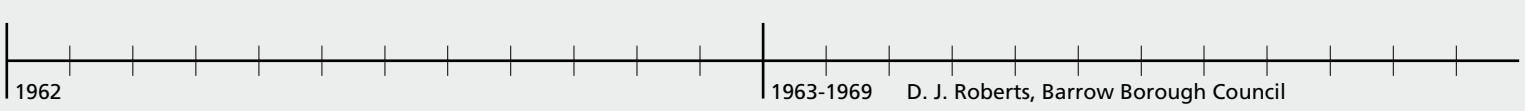
remain stronger than ever. The Carlisle Partnership – whose partners include public, private, voluntary and community sectors – set out in the community plan how we will work together to take forward Carlisle Renaissance and provide quality services for local people. Discussions are taking place as to the development of a Healthy Cities initiative for Carlisle, based on the Healthy Cities project of the World Health Organisation. This will have significance for other towns and communities across the county over the next few years.

As Carlisle and District is one of Cumbria's two Spearhead authority areas, we have been working to reduce the gap in infant mortality and improve life expectancy in the areas with the worst health and deprivation via lifestyle interventions. As a collective undertaking, the Carlisle Healthy Communities thematic task group worked to reduce the number of smokers by training local people to help friends and colleagues quit their habit. This team of supporters also signpost smokers to the Stop Smoking Service; 40% of the population in our two most disadvantaged wards smoke compared with under 20% in more affluent areas. There is a similar correlation between deprivation and obesity so partnership work has been developed to promote healthier eating. Health Impact Assessment on policies and interventions in these areas inform future activity to improve the health of local people and the recommendations in this report will shape the work for the coming years.

West Cumbria Strategic Partnership is a way of working among a network of community, voluntary, private and public organisations to improve social, economic and environmental wellbeing of West Cumbria. The Partnership helps to provide strong leadership in West Cumbria by supporting the creation of the Sustainable Community Strategy.

The partnership brings organisations together so they can plan the best ways to deliver local services. It also monitors the ways in which public services are being delivered. One of the (thematic) groups of the partnership is the Healthy Communities Group; this has the responsibility of monitoring and reducing the gap in health inequalities and has developed a detailed delivery plan focusing on initiatives to improve health in West Cumbria and reduce the health inequalities gap. A great deal of activity has resulted from this plan such as brief intervention training for service providers and communities on issues such as smoking, reducing alcohol use, healthy eating and increasing physical activity.

2008 gives the opportunity to work even more closely with partners to narrow health inequalities by targeting the prevention of cardiovascular disease and cancer alongside lifestyle and wider determinants of health such as employment and housing. Together with key partners we will be developing a Health Inequalities Improvement Strategy for Carlisle and District and for West Cumbria to explore the



gaps in infant mortality and life expectancy. The strategy will form the basis for agreed interventions that will make a strong impact on the inequalities gap that exists across North Cumbria.

While the Health Improvement Teams deal with a variety of issues and methods, other colleagues fulfil a very focused and specialised role. For example, the Intelligence Team works to support the Directorate with statistical and data analysis services, whilst a Communications Lead – working exclusively with public health – provides a variety of publicity and media support.

Improving Health

Health is an outcome of all the various factors affecting our lives. Major improvements in community and individual health and a reduction in health inequalities can only be achieved through frameworks for action which support individuals in adopting healthy lifestyles, improving access to health care, income, housing, environment, transport and education and other factors contributing to poor health. Partnership working and close collaboration with local communities is therefore essential.

Health improvement action starts with the whole population, and encompasses more specifically targeted work with particular groups or communities to address health inequalities. In Cumbria a particular focus for health improvement work is given to Barrow, Carlisle and West Cumbria in communities where there are higher levels of disadvantage and associated poor health.

The five key strategies needed to improve health are:

- Building healthy public policy
- Creating supportive environments
- Strengthening community action
- Developing personal skills
- Reorientation of health services

The local strategic partnerships at county and district levels in Cumbria, alongside the planning mechanisms of the Cumbria Local Area Agreement provide the necessary infrastructure to plan and co-ordinate action to improve health across agencies. This infrastructure provides the context for setting targets to support the delivery of Choosing Health and other key health improvement policy frameworks, focussing action on specific locally agreed health improvement priorities such as obesity, smoking, alcohol, physical activity, mental health and sexual health.

One key approach in health improvement work is to identify organisations and communities which provide "settings" through which systematic action can be

developed for health gain. Examples of settings could include schools, prisons, hospitals community health or care centres, children's centres, workplaces. A key part of the health improvement strategy is to support organisations in developing their capacity and competencies to influence positive health outcomes.

Another key approach is the PCT's own efforts to re-orientate primary care and hospital services and mainstream health promotion activities within all local NHS activity. The NHS plays an important role in supporting individuals in adopting healthier lifestyles. For example, health professionals are being encouraged to highlight to their patients the importance of stopping smoking. At the same time the PCT is giving high priority to improving access to stop smoking services, by making sure that they are easily available in the communities where they are most needed. Programmes such as developing the skills of "health trainers" and piloting the Department of Health's initiative, the "Self Care for You" programme, will support individuals in taking steps to improve their health. These programmes are being developed in close collaboration with community partners and colleges in priority areas.

Example: Helping Cumbria's children grow up healthy

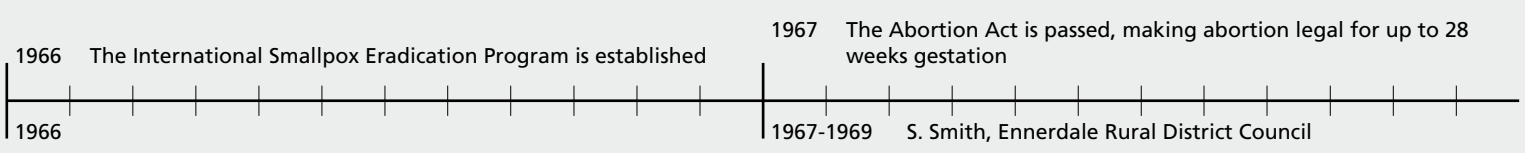
Tackling obesity among children is one of the key health improvement priorities, providing a good example of the way various strands of activity can be taken forward through partnership working. As recommended in Choosing Health, the dual approach of improving diet and nutrition alongside increasing opportunities for physical activity has been applied to programmes across the whole county.

Table 28: Levels of Overweight and Obesity in Cumbrian Children, 2006-07

Children classed as overweight in Reception class (5 year olds)	13.6% of total in school year
Children classed as overweight in school year 6 (10-11 year olds)	13.3% see note below
Children classed as obese in Reception class (92% of all measured)	10% of total in school year
Children classed as obese in year 6	15.5%

N.B. Whilst the measurement data for Reception year children in Cumbria is fairly robust at 92% out of all new starters, Year 6 data is not as extensive and should therefore be interpreted as preliminary figures. This difference is due to the measuring process not being universally adopted across the county for Year 6 children at that time.

To ensure that children in Cumbria achieve a healthy weight the following activities are underway: As part of a national child measuring programme, school nurses



work collaboratively with schools and parents to measure the heights and weights of reception year and year 6 primary school children. This enables the PCT and its partners to monitor the trends in childhood obesity in Cumbria and give extra support to areas where this is a greater problem.

Standards have been set for all food served in school, through the Cumbria Healthy Schools Balanced Eating Steering Group. This work has included workshops on developing school food policies and food education for governors, teachers and catering staff. These have been attended by over 70% of schools. By July 07 the target of 50% schools achieving Healthy Schools accreditation was attained, which means they had successfully met the new criteria for food in schools. Work around 'food miles' has also been progressing to increase the amount of local produce in school meals. This has wider spin offs for the local environment and economy.

Actions through multiagency partnerships such as the Cumbria Sport Board and Physical Activity Forum, to improve children and young peoples' participation in sport and everyday physical activity. All districts have Sport and Physical Activity Alliances which are delivering action plans to increase participation.

Actions are underway to encourage and support breastfeeding and healthy weaning by mid-wives, health visitors and other community staff and volunteers.

The PCT is developing new pathways of support for children who are obese or overweight.

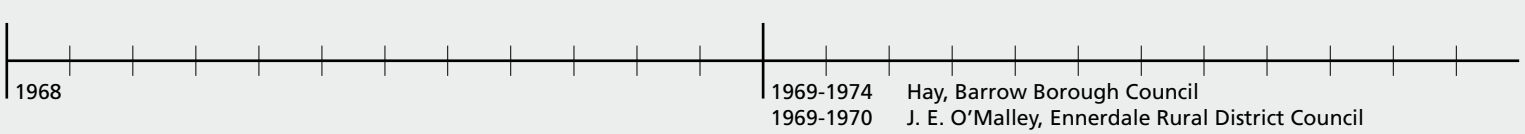
Health Protection

Often perceived as a silent mainstay of our service portfolio, health protection has recently been elevated to a more prominent role.

Emergency Planning and Preparedness

The Civil Contingencies Act came into force in 2004 and identifies National Health Service bodies as playing a crucial role in planning for, and response to emergency incidents. For the first time, Primary Care Trusts have been designated as Category 1 responders. As such, Cumbria Primary Care Trust is required to have robust multi-agency mechanisms in place to ensure an effective incident response.

The Act consists of two parts: Part 1 covers local arrangement for civil protection, setting out clear roles and responsibilities for those involved in emergency preparation and response at local level, whilst Part 2 covers emergency powers. Cumbria Primary Care Trust is subject to the full set of civil protection duties which includes:



- Assessing the risk of emergencies occurring and using this to inform contingency planning;
- Putting in place emergency plans and Business Continuity Management arrangements;
- Providing information to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency;
- Sharing information with other local responders to enhance co-ordination, and,
- Co-operating with other local responders to enhance co-ordination and efficiency.

The Trust's requirements for preparedness were extended further in 2005, when the Department of Health published 'The NHS Emergency Planning Guidance', a set of general principles to shape all National Health Service organisations' ability to respond, and to recover from, major incidents.

The Greyrigg Train disaster in February 2007 was the first multi-agency incident that tested the new Trust's ability to respond. Lessons learned from that incident have been incorporated in the Major Incident Plan.

In May 2007, a new Emergency Planning Officer was appointed to support the Chief Executive in the discharge of their duties for emergency preparedness. The Emergency Planning Officer's role includes:

- Development of a Major Incident Plan which outlines key roles and responsibilities, procedures and systems needed to deal with a major incident in Cumbria;
- Participation and at the multi-agency Cumbria Local Resilience Forum subgroups, deputising at the Cumbria Local Resilience Forum when required;
- Development of multi-agency plans, which include training and preparedness exercises;
- Emergency planning input into regional and local Pandemic Influenza groups;
- Development, amendment and validation of Control of Major Accident Hazards
- Regulations 1999 and Radiation (Emergency Preparedness and Public Information) Regulations 2001 off site plans;
- Leading on this agenda for Cumbria Primary Care Trust and working closely with the emergency planning colleagues in both Acute Trusts, the Cumbria Partnership Foundation Trust and North West Ambulance Service;
- Participation in the Trust Business Continuity Management Group to develop their strategy and policy, and
- Development of the Cumbria Primary Care Trust Pandemic Influenza Plan.

The importance of emergency preparedness cannot be overestimated. In his "Operating Framework for the NHS in England 2008/09", Chief Executive, David

Nicholson instructs that the Health Service must be prepared for "…emergencies and problems that affect the population as a whole, things like outbreaks, pandemic flu. So a major priority for us [is] to get our planning absolutely right so the NHS can deal with any eventuality that arises over the next period".

Throughout 2008 not only will the Primary Care Trust apply national policy developments in emergency planning as they emerge, there will also be an emphasis upon continued staff training to ensure any required response is executed in an appropriate and timely manner.

The benefits of having specialist health protection input have already proved invaluable, as seen with incidents such as the recent salmonella outbreak in West Cumbria. A core function of health protection is the ongoing status monitoring of both national and international threats such as infectious diseases such as pandemic influenza or biological and chemical agents that could be used in a terrorist attack. Surveillance of these trends helps to inform other such as vaccination and immunisation. A lot of work goes into planning and delivery of these programmes for both children and adults and is an important part of protecting population health through intelligent prevention.

After clean water, vaccination is one of the most effective public health interventions in the world for saving lives and promoting good health. Vaccination provides one of the safest, most effective, means available to society for reducing death and disability. The United Kingdom has an enviable record on achieving high uptake rates and this has led to dramatic reductions in illness and death from communicable diseases. It is important to realise though, that diseases are only held at bay by vaccination and can still cause problems. It is unfortunate that misinformation and misrepresentation in the media has led to increased public scepticism about the safety of the vaccination programme with the result that not all parents choose to vaccinate there children. In Cumbria, although we have uptake rates well above the national average, we are always striving to improve on them

Vaccination programmes are not just for children, People over 65 or "at risk" due to other medical conditions are offered vaccinations against pneumococcal infection as well as an annual flu vaccination. Extra vaccinations may be required for those in certain jobs and those of us who enjoy travelling will know of the importance of travel vaccinations.

Running the vaccination programme is very complex, constantly changing, and a large number of individuals and groups contribute to its smooth running. Over the past few years we have seen changes to the TB vaccination programme, several changes to the childhood vaccination schedule including the introduction of

pneumococcal vaccine and an extra dose of Hib. Currently we are planning the introduction the new cervical cancer prevention vaccine for all year 8 girls aged 12/13 years from September 2008

Screening programmes:

Breast Cancer Screening

In line with the rest of the country, breast cancer diagnoses have been rising in Cumbrian women, although the numbers of deaths have fallen slightly. The table shows the numbers of cases and numbers of deaths by year from 1995 to 2006 inclusive.

Table 29: Breast Cancer in Cumbria, Cases and Deaths, 1995-2006

Year	Number of Cases	Number of Deaths
1995	282	128
1996	328	121
1997	311	118
1998	348	123
1999	340	126
2000	407	126
2001	370	115
2002	371	112
2003	402	109
2004	423	101
2005	n/a	88
2006	n/a	119

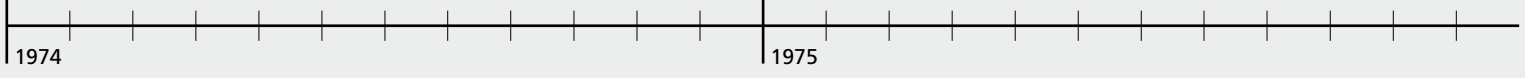
The NHS Breast Screening Programme provides breast screening services every three years for all women in the UK aged 50 – 70 (increased from 50 - 64 in 2005), with routine screening available to those over 70 on request. The national minimum standard for uptake rates is 70% and this has been achieved in Cumbria although there is variation at Local Authority area level.

The table shows the latest uptake rates by age group for Cumbria:

Table 30: Breast Screening Uptake in Cumbria, 2004-7

	Number of eligible women	Number screened	% screened in last 3 years
Women aged 53-64 years	40,352	31,716	78.6%
Women aged 50-52 and 65-70 years	25,662	13,351	52.0%
Women aged 50-70 years	66,014	45,067	68.3%

1974 Contraception becomes free of charge on the NHS in 1974, prompting an immediate fall in the teenage pregnancy rate



Breast screening services at the Cumberland Infirmary and West Cumberland Hospital are sited within their own self-contained units in quiet areas of the hospitals. The Eden Breast Cancer Unit at the Cumberland Infirmary was expanded and refurbished in late 2005 to also provide a dedicated imaging service for women with symptomatic breast cancer in North Cumbria. Women from South Cumbria and North Lancashire are offered screening at a dedicated unit in the Royal Lancaster Infirmary.

Cervical Cancer Screening

Each year, there are around 10 or so deaths from cervical cancer in Cumbria. The table shows the number of cases diagnosed and number of deaths each year from 1996 to 2006 inclusive (Information Centre for Health and Social Care).

Table 31: Cervical Cancer in Cumbria, Cases and Deaths, 1996-2006

YEAR	Number of Cases	Number of Deaths
1996	31	15
1997	27	12
1998	28	14
1999	23	9
2000	23	7
2001	41	8
2002	25	11
2003	24	-
2004	19	11
2005	n/a	9
2006	n/a	3

The national policy for the cervical screening programme is that eligible women (aged 25 to 64 years) should be screened every three or five years, varying according to age.

Women aged 25-49 are screened every three years and those aged 50-64 every five years. In 2003, the NHS Cervical Cancer Screening Programme introduced Liquid Based Cytology (LBC), a new method of collecting and preparing cervical samples that increases the accuracy of tests and speeds up the processing of samples. Liquid Based Cytology for cervical cancer screening has been fully implemented across all the laboratories within Cumbria.

There are just over 125,000 eligible women in Cumbria who are eligible for cervical screening and 82% of these women have been screened in the last 5 years. Nationally, 79% of eligible women have been screened.

Opportunistic Chlamydia Screening

The National Chlamydia Screening Programme in England aims to prevent and control chlamydia through early detection and treatment of asymptomatic infection, reduce onward transmission to sexual partners and prevent the consequences of untreated infection.

The aim is to achieve this through the implementation of a multi-faceted, evidence-based and cost-effective national prevention and control programme across England. The programme ensures that all sexually active men and women under 25 years of age will be made aware of chlamydia, its effects, and have access to services providing screening, prevention and treatment to reduce their risk of infection or onward transmission.

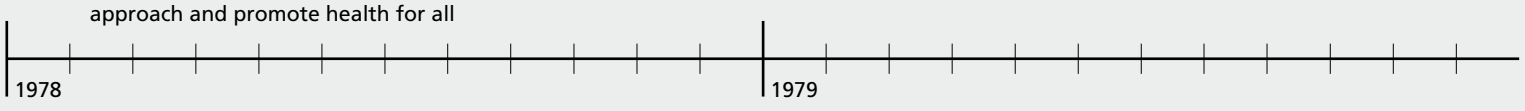
Chlamydia screening advisors are based in Carlisle, Workington, Kendal and Barrow. The focus of the service provision is not in Genitourinary Medicine clinics where testing already takes place, but in a variety of community based settings including 70 GP practices and many voluntary organisations across the county. Local chlamydia screening coordinators work to facilitate screening in colleges and other educational settings, in youth and community centres including Connexions centres. Also, by working with schools, the programme ensures that the issue of chlamydia is discussed and understood.

From when the screening programme went live in October 2007 to February 2008, the total screened to date is 2,400.

Did You Know…?

The rate for road injuries and deaths is higher in Cumbria than the North West and England. An average of 400 people die or are seriously injured on the county's roads each year.

1978 The World Health Organisation adopts the Declaration of Alma-Ata, urging all governments to adopt the Primary Health care approach and promote health for all



Case Study: MRSA in Cumbria

Possibly the two most infamous 'superbugs', methicillin-resistant Staphylococcus Aureus (MRSA) and Clostridium difficile (C. diff) can cause healthcare-associated infection.

These infections are a risk in hospitals because of a number of factors: Many medical procedures are 'invasive' (for example taking a blood sample) and so bypass the body's natural protective barriers, leaving patients susceptible to bacteria. As patients often have weakened immune systems, the risk of catching and spreading infections is greater, especially for longer-stay patients. Indirect contact with contaminated areas or even airborne transmission via dust or a sneeze can trigger further spread.

Treatment using anti-microbial treatments like antibiotics can help remedy these problems, but over-use on a routine basis can have the opposite effect and has been a major factor in the emergence of resistant strains: Both MRSA and C. diff are characterised by their resistance to antibiotics.

The single most effective way to combat cross-infection is correct and thorough hand washing. The use of alcohol rubs by clinical staff before each patient contact, and appropriate use of gloves and aprons also play an important part.

Within Cumbria, the numbers of MRSA and C. diff cases are low compared to other areas, although we still need to achieve the Government targets of 50% reduction. The measures used to help attain this target are staff education, training, effective decontamination procedures and cleanliness inspections . A well-received infection control conference was held in June 2007.

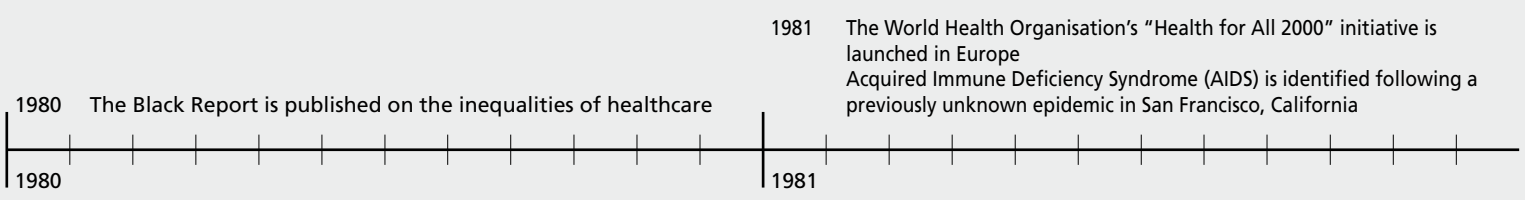
What does the Health Protection Agency do?

The Health Protection Agency is an independent body whose work protects the health and well-being of the population.

Formed in 2003, the Agency plays a critical role in protecting people from infectious diseases and in preventing harm when hazards involving chemicals, poisons or radiation occur.

A key part of the Health Protection Agency's remit is to work closely alongside Public Health teams or Health Care Trusts in order to prepare for new and emerging dangers, such as a bio-terrorist attack or virulent new strain of disease.

The Health Protection Agency in Cumbria is represented by a small team comprising a Consultant in Health Protection and Health Protection Nurse who are based within the PCT and support Local and Regional Service provision.



Public Health Commissioning

Good health is something we all want for ourselves, our families and our friends. As the commissioners of health services for the people of Cumbria, Cumbria Primary Care Trust aspires to build the best community care in the country and to begin shifting healthcare from our hospitals to closer to home where appropriate. The public health teams works closely with commissioners to support the work they do. Together we are commissioning services that help more people keep fit and well for longer. We are helping to redesign services that put local people at the centre of care, are more responsive to people's needs and reflect local priorities.

We cannot continue to provide health services in the way that we do now. Cumbria has a high proportion of older people – one in four of our population is over 65 and the numbers are rising. We know that smoking, excessive drinking and obesity are becoming the modern epidemics and that we need to invest in promoting health in order to keep people healthy for longer. We know too that these 'life styles' are heavily influenced by a person's environment – political, social, cultural, economic and physical. The most pervasive risk factor for illness and disease in Cumbria today is still poverty.

Most people using health services have long-term conditions such heart disease or diabetes. Although we have seen great advances in medical technology we still do not have a cure for these conditions though better treatments mean that many people will live independently in the community for many years. We need to provide more care for people in their own communities so that they can continue to live in their own homes. Already we treat too many people in hospitals and without this move our hospitals will become overwhelmed. Some people would say that Britain is 20 years behind in making this shift. Other countries such as France, Finland and Sweden started making this move many years ago. They now have first class health care where it is needed – in the community.

We are working closely with key partners including local government, healthcare providers and third sector organisations to commission services that improve the overall level of health in Cumbria whilst reducing the inequalities between our most well-off and disadvantaged areas. Together we are developing a shared vision to encourage innovation and continuous improvement in services. Philosophically we have turned a corner – we are commissioning for health gain and not just commissioning treatments.

As public health commissioners, we need to have a good understanding of what really matters to patients, the public and staff. We need to ensure that services are designed to meet the changing needs of the local population and shift the focus of

care from diagnosis and treatment to prevention and well-being. Health intelligence, analysis and research are vital to support effective commissioning, monitor health trends and develop health improvement programmes and policies. We need to start capturing high quality, accurate and timely information about health in Cumbria. We have already brought together our key partners to establish the Cumbria Intelligence Observatory which will ensure that a wealth of information on all aspects relevant to health in Cumbria is readily available.

The public health partnership with commissioning will ensure that Observatory information on the wider determinants of health will be taken into account when considering how to improve the health and well-being of people in Cumbria. We are undertaking a Joint Strategic Needs Assessment in collaboration with Cumbria County Council to develop a full understanding of the needs of people living in Cumbria. This will help us to focus on a number of local commissioning priorities that reduce health inequalities, provide services closer to home, reduce the use of acute hospitals and are based on best clinical practice.

Ultimately, our goal is to deliver long-term improvements in the health and well-being of our local communities; adding life to years and years to life.

Partnership Working and the Local Area Agreement

Partnership working is vital to achieving health improvement and reducing inequalities. The major challenges we face in achieving improved health for all, and in particular in reducing inequalities in health, can only be tackled effectively by a concerted effort by many sectors. Each of the current major concerns around health, such as obesity, alcohol, or tobacco, requires collaborative work across a range of partners, to enable and support the changes necessary to achieve improvement.

Taking smoking as an example, we have made significant progress in recent years in reducing the prevalence of smoking, but smoking rates are still worryingly high, especially in manual groups and amongst those without work. The ban on smoking in workplaces and public spaces which came into force last year has encouraged some smokers to make the step of giving up for good, and the development of effective Stop Smoking Services in the NHS has supported increasing numbers of smokers to quit.

However if we are to make significant progress in reducing smoking, especially amongst our most disadvantaged groups and amongst young people, we now need to tackle issues such as access to cheap counterfeit and smuggled tobacco, and to

strengthen enforcement of age-of-sale legislation, in order to reduce consumption and discourage uptake.

Public health has long advocated the importance of working on the determinants of health, rather than focussing only on health care itself. These determinants, including for example housing, education, social cohesion, work/unemployment, transport, are mainly the responsibility of organisations other than the health system, and are often best (or only) delivered in partnership.

Partnerships which are working to improve health in Cumbria include:

- Healthier Communities and Older People Thematic Partnership
- Cumbria Alcohol Strategy Group (Drug and Alcohol Action Team)
- Smoke-Free Cumbria Strategic Alliance
- Health and Well-being Board
- Cumbria Sports Partnership
- The Public Service Board for Cumbria
- The establishment of a joint Health Unit with Cumbria County Council

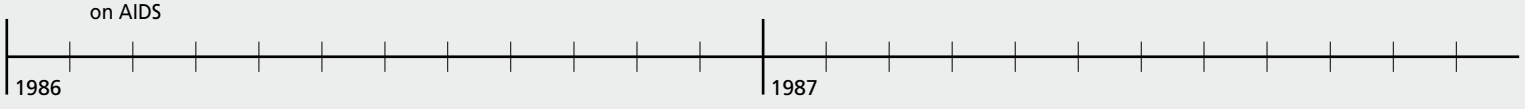
The Local Area Agreement (LAA) is now the main vehicle through which central government works with Local Authorities to identify and agree local priorities and targets for performance improvement. Cumbria's LAA was negotiated with a wide range of partners, and has been 'live 'since April 2007. Cumbria's LAA was developed around 5 themes:

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

Public health staff play a key role in this work through involvement in the Healthier Communities and Older People Thematic Partnership at County level, and through leadership of local health partnerships at District Council level, which contribute to the development and delivery of the LAA.

The LAA builds on earlier planning processes and needs assessments, and links to the longer-term Sustainable Community Strategy, which is led by the Cumbria Strategic Partnership. The LAA strengthens the role of partnership working by highlighting issues where working together has real added value in the delivery of outcomes for Cumbria's people. The process focuses the thinking and resources of a range of agencies on agreed, shared priorities and demands joint planning and aligning

1986 The World Health Organisation Healthy Cities programme is launched in Lisbon to engage local governments in health development
Government launches the biggest ever public health education campaign on AIDS



of budgets. Through identification of specific and measurable targets, agencies and partnerships are committed together to achieving real improvements for the population.

Priorities for health improvement have been incorporated into all of the key themes. Within the Healthier Communities theme we find:

"Combat the rise in obesity by increasing adult participation in sport and active recreation"

Whilst the Children and Young People theme includes:

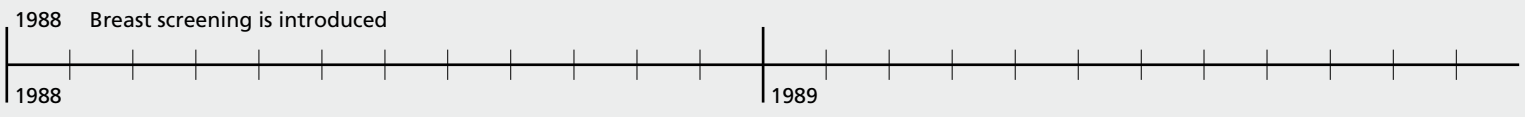
"Increase the percentage of schools with a school travel plan"

– an indicator which will contribute to the achievement of reduction in obesity through encouraging people to be more active in their daily lives.

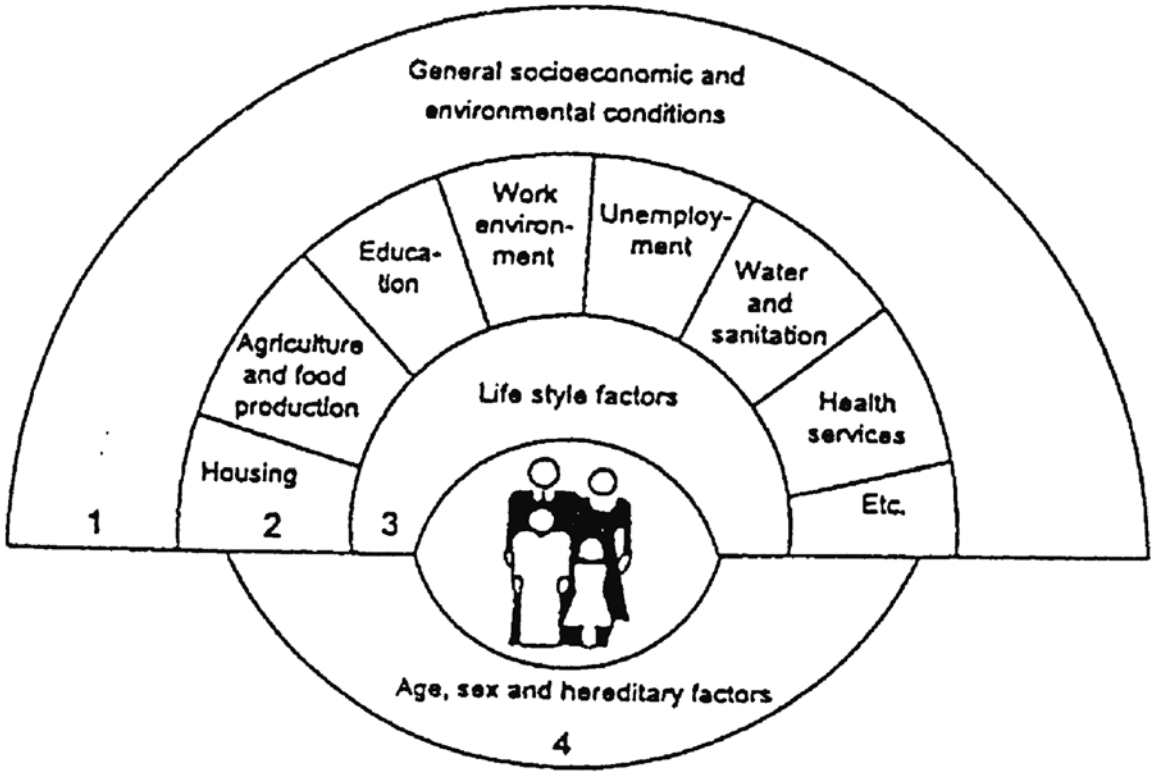
In 2007 the Department for Communities and Local Government moved to a "New LAA" approach, incorporating new set of National indicators and requiring renegotiation of our agreed priorities and targets. We are building on our shared learning in the 2007-8 LAA to ensure that the excellent foundations for partnership working which were built through the development of Cumbria's original LAA are used to best effect in negotiating a refreshed Local Area Agreement for Cumbria which will take us through to 2011. Public Health is a strong feature of that developing Agreement.

Investment for health

Health is mainly gained and lost outside of medical care. The underlying determinants of good health are to be found in the environments of everyday life, in people's social and economic circumstances and the interaction of lifestyles and behaviour with those circumstances.



Health Determinants



Source: Harrington, P. & Ritsatakis, A. *European Health Policy Conference: opportunities for the future. Volume II – Intersectoral action for health*. Copenhagen, WHO Regional Office for Europe, 1995 (document EUR/ICP/HFAP 9401/CN01(II), page 12).

Investment for health relates to investment across a range of sectors and agencies which has a positive impact on health outcomes. This then becomes a 'virtuous circle': a healthier population will make a more productive contribution to overall development, and require less social support in terms of health and welfare services and benefits. This can be described as the 'health dividend' – health benefit obtained from social, environmental and economic activity which is not primarily health focused.

A good example of investment for health is the Settings Approach, and the most familiar example of this is Healthy Schools. Whilst the primary purpose of a school is to achieve educational outcomes, where a school recognises and acts on its potential to improve the health of its students and staff through the way it conducts its routine business, health benefits are realised also. Thus, by investing in healthier school meals, challenging bullying, or supporting a walk-to-school policy, a Healthy School can contribute to improved health outcomes in terms of obesity and mental health.

Resources for Health in Cumbria

Across the county we have access to a wealth of amenities that contribute to our levels of health and quality of daily life, including:
2 National Parks
Innumerable lakes, mountains and fells:
There are only four English peaks over 3000 feet and they are all in Cumbria:
Scafell Pike 977m (3210 feet)
Scafell 964m (3162 feet)
Helvellyn 953m (3116 feet)
Skiddaw 934m (3054 feet)

351 Churches in the Diocese of Carlisle
44 Main Public Parks
16 SureStart centres
104 Nursery Schools
279 Primary Schools
42 Secondary Schools
48 Libraries
6 Colleges
27 Adult Education Centres
34 Community Centres
16 Leisure Centres

99 Doctors Surgeries
100 Dental Surgeons
12 Mental Health Inpatient Units, with a variety of Community and Specialist Mental Health services county-wide
4 General Hospitals

Chapter 10: Endpiece

The first Public Health report on the health of Cumbrians marks the beginning of a journey. We hope that this journey will take us somewhere that our grandparents could only have dreamed of – a place to live where being born, growing up and living one's life can be done to the full without the threat of ill-health to blight our dreams; And when our personal journeys are over, that we spend our final days in comfort and dignity in one of the most beautiful parts of the world in the company of our family and friends without undue recourse to intrusive medical intervention.

We have some way to go, but the glass is half-full. On some indicators, safe entry into the world and life expectancy we compare well with the country as a whole and with our reduction in heart disease deaths we are ahead of the curve. But in other areas – teenage pregnancy, obesity and suicide we have a great deal to do. What is unacceptable are the big inequalities which exist in health experience between different areas and groups across the County. To rectify this, Cumbria PLC and Cumbria Health will need to be as one with the Community. The prospects could be good. There are signs of a new galvanised sense of purpose across the agencies and bodies that represent Cumbrian civic life, the Health Service has a recovery plan and some stakes are being put in the ground. An integrated Observatory will soon provide shared intelligence between the County Council, Police, Fire and Rescue, NHS and many other agencies in the county. New partnership arrangements are beginning to bear fruit and we are beginning to speak with one voice. Sir Derek Wanless' Fully Engaged Scenario begins to seem like a possibility here in Cumbria. I hope that next year's report will bring good news – in the meantime there is a great deal to do.

The memories shared by Jennie and Percy, our Centenarian contributors, remind us that not only is good health a valuable resource to be nurtured at any age, but a truly healthy life is a balanced state of being in which to enjoy variety, meaning and fulfilment. If we can follow their examples and adopt those values amid today's fast-paced Twenty-First Century lifestyles, we will each build a solid foundation for whatever health challenges lie ahead for us.

I would like to thank especially those members of the Cumbria Public Health Team who have worked so hard to produce this report.

JRA

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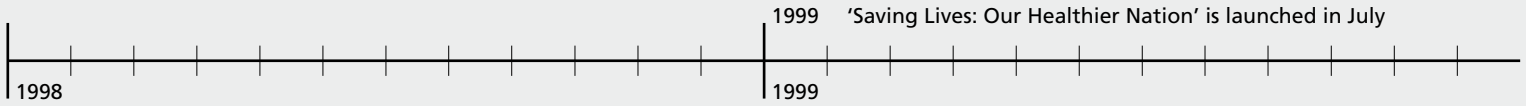

Our Partners:

Building health in a particular area relies upon good relationships and joint working with other organisations. This list is not intended to be exhaustive, but merely to reflect the diversity of our partners in Cumbria.

Allerdale District Council

Barrow-in-Furness Borough Council

Business Link Cumbria

Carlisle City Council

Cumbria Chamber of Commerce and Industry

Churches Together

Copeland Borough Council

Cumbria Association of Local Councils

Voluntary Action Cumbria

Cumbria Constabulary

Cumbria County Council

Cumbria Rural Enterprise Agency

Eden District Council

Invest in Cumbria

South Lakeland District Council

2001 A major Foot and Mouth disease (FMD) outbreak spreads across rural areas nationwide: Cumbria is one of the most affected counties, resulting in much hardship and distress

2000 2001

South Lakeland Strategic Partnership

West Cumbria Strategic Partnership

Rural Regeneration Cumbria

Cumbria Sport

Sport England

University of Cumbria

English Nature

Eden Homes

Kendal College

Connexions Cumbria

Learning and Skills Council

Eden Local Strategic Partnership

National Probation Service

Northwest Development Agency

Cumbria Community Foundation

JobCentre Plus

Cumbria Fire & Rescue Service

2002 Barrow-in-Furness experiences the third largest reported outbreak of Legionella in the world, revealing weaknesses in the public health infrastructure

2002 2003

Cumbria Local Enterprise Agency Network

The National Trust

Cumbria Youth Offending Service

Cumbria Vision

And:

Arts Council, North West
CBI North West
Countryside Agency
Cumbria Association of Councils for Voluntary Service
Cumbria Cultural Forum
Cumbria Tourist Board
Environment Agency
Innovia Films
Lake District National Park
National Farmers Union (NW)
Pirelli Tyres Ltd
Sure Start
West Lakes Renaissance
District/Borough Local Strategic Partnerships
Action For Health network, supported by
Cumbria CVS,
Voluntary Action Cumbria
Age Concern
Cumbria CVS
Forestry Commission
MIND

2004 The 'Choosing Health' White Paper on improving the nation's health is published in November, and includes a proposal to ban smoking in all public places

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With thanks to the West Cumbria Community Strategy 2006-7 and the Carlisle Community Plan 2007 for background information on North and West Cumbria

2006 Liverpool City Council sponsors a tobacco control bill in the House of Lords, prompting the House of Commons to introduce its own legislation
Cumbria Primary Care Trust is created on 1st October

2007 Cumbria Primary Care Trust and Cumbria County Council appoint a joint Director of Public Health
England's smoking ban comes into force on 1st July.

2006 2007

Further Reading

http://www.johnrashton.securemachines.co.uk/web/biography.asp