Living Well in Cumbria

Summary Report

For the Director of Public Health and the Cumbria Intelligence Observatory

Supporting Cumbria's Joint Strategic Needs Assessment

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Foreword

This, the fourth in the series of reports on health in Cumbria which have been commissioned from Liverpool John Moores University, is intended to provide a snapshot and a reference point for adult health in the county.

By the time we reach adult life our health futures have already begun to diverge. We can look at the raw data on birth and death across our communities and see how the Grim Reaper visits us differently because of our postcode. However, by giving attention to the everyday life of adults we can gain insights as to where things are beginning to go systematically adrift while there still may be time to take remedial action.

This report is relevant to a wide range of individuals and agencies across Cumbria who are in a position to influence and shape the health conditions which influence the risks to life and health which flow from the picture painted here. I would encourage all readers to reflect on how they might make a difference to the trajectories of ill health which are implied in these pages.

Professor John R Ashton CBE
Director of Public Health and County Medical Officer for Cumbria
May 2011

Key messages

- A large majority of adults in Cumbria now enjoy good health and are materially wealthier than previous generations. There are many achievements to celebrate including longer life expectancy and fewer early deaths. However, there are still many challenges to meet such as increasing levels of obesity and the long-term damage caused by smoking and alcohol consumption. Most importantly, despite the progress that has been made, the people of Cumbria are not happier with their lives than their parents were a generation ago. Mental health and wellbeing is becoming an increasingly important part of what *living well* means for people in wealthy societies.
- The solutions to these challenges need to be developed in an era when public spending is going to be constrained. New ways of engaging, enabling, empowering and persuading people that *living well* is everybody's business need to be found. Cumbria's greatest assets are its people and communities. This tremendous resource needs to be developed so that progress continues to be made. Services based on the active participation of the public and professionals in genuine partnership are a promising way to improve the quality of life for all people across the county.
- The social determinants of health for adults, such as employment and housing, must be tackled in order to improve health and wellbeing. Purposeful, paid work is vital to this and addressing the needs of people who are long-term sick or disabled is also an essential step in this process. We need a healthy workforce and to continue to develop innovative ways of supporting people who are long-term sick or disabled to make the transition into paid work. Ensuring that more people enjoy financial security is an essential step in regaining our sense of wellbeing.
- There are housing issues that urgently need to be addressed in Cumbria. The affordability of property is a problem in many parts of the county given the increase in house prices in relation to wages over the last decade. The availability of social housing is also a problem and needs to be improved if communities are to remain cohesive. Finally, homes that meet the Housing Health and Safety Rating Standards for 'decent homes' (including their fitness for habitation and degree of thermal comfort) in the private and social sector are required.
- Our mental health and wellbeing, how we feel about life and function on a daily basis, is at the core of *living well*. According to the North West Mental Wellbeing Survey, Cumbria had a slightly lower level of wellbeing than the regional average with 61.9% of the sample having a moderate level of wellbeing (compared with 62.8% in the North West), 24.2% having a low level and 14.9% having a high level of wellbeing.
- Mental health and wellbeing is related to enjoying good general health and life satisfaction across a number of areas such as personal relationships, financial security and trust in other people. South Lakeland (27.5%) had the largest proportion of adults with an above average level of wellbeing, while Eden (44.7%) and Carlisle (40.9%) had the largest proportion with a below average level of wellbeing.

- People with long-term conditions, such as hypertension and diabetes, can have complex and on-going medical needs and action must be taken to prevent or delay such conditions. Once a person has developed the condition they must be shown how to self care so that they can manage their health as well as possible, for example through the provision of patient programmes such as diabetes education (DESMOND).
- We need to develop new ways of changing people's behaviour in relation to alcohol, smoking, eating and physical activity if we are to reduce the number of people developing long-term conditions such as diabetes and delay the diseases of affluence such as heart disease that still claim too many lives too early.
- The challenges facing public health are particularly evident by the increase in the proportion of the population who are clinically obese. Nearly 1 in 4 adults are obese and therefore at greater risk of developing long-term conditions such as hypertension and diabetes that increases their risk of heart disease and stroke. There are more than 95,000 obese adults in Cumbria, a total that is forecast to continue to increase unless people begin to lead healthier lifestyles. While the proportion of all adults in Cumbria who are obese is slightly lower than it is in England (23.2% compared to 24.0%) there are areas of the county such as Barrow-in-Furness (26.9%) and Copeland (26.8%) where it is somewhat higher.
- Eating healthily is an important part of leading a healthy lifestyle and eating five portions of fruit and vegetables a day is a benchmark for this. It is estimated that 28.4% of adults in England achieve this, however in Cumbria it is slightly lower at 27.3% of all adults (approximately 112,100 people) and it is lower still in Barrow-in-Furness (21.1%) and Copeland (21.3%).
- Today's population spend much more time sitting down and less time being physically active compared to previous generations. Being physically active improves fitness; reduces the risk of heart disease, stroke, Type 2 diabetes and some forms of cancer, reduces the risk of depression and improves mental health and wellbeing. Being physically active for 30 minutes a day for five days a week is the recommended benchmark but it is estimated that just 11.5% of all adults, approximately 47,400 people, are physically active in Cumbria.
- Reducing obesity along with increasing healthy eating and physical activity, poses a complex set of challenges. We need to change people's behaviour, encouraging positive choices by nudging social norms for individuals and devising innovative means of engaging people with lifestyle change. The natural environment in Cumbria provides great opportunities for physical activity and we need to make full use of this.
- Smoking is still the single greatest cause of preventable illness and early death despite the proportion of people who smoke falling in England from 28% in 1998 to 21% in 2008. Cumbria had a slightly lower estimated prevalence of smoking than England, however there are still nearly 90,000 adults who smoke in the county, with Carlisle having the highest level. There is still a long way to go to reduce the 900 deaths per year in the county due to smoking. It is difficult for people to give up smoking but it easier with the assistance of NHS stop smoking services which in Cumbria helped 3,732 people to quit in 2009/10.

- Alcohol can cause harm in many ways for individuals, families, neighbourhoods and wider society. Areas of Cumbria such as Allerdale, Barrow-in-Furness, Carlisle and Copeland have some of the worst indicators of alcohol harm in England in terms of hospital admissions. Although the majority of adults drink alcohol within safe limits, around 10% of people were drinking at a level that is hazardous to their health and 2.2% at a harmful level. It is vital to reduce the harm that alcohol can cause through interventions aimed at high risk individuals and the whole population.
- Obesity, healthy eating, physical activity, smoking and drinking alcohol all show a social gradient, they are more common among people living in the more disadvantaged parts of the county. Improving health and co-producing services must include and involve people from these communities if we are to achieve sustainable change and improvement.

Living Well in Cumbria

The report, *Living Well in Cumbria* is the fourth in a series that examines the population of Cumbria from birth to death. It considers the health and wellbeing of adults of 'working age' from their mid-twenties to their sixties and examines the many factors that affect a person's ability to lead a full and healthy life in Cumbria:

- the social determinants of health – the economic, social and environmental factors that shape how we lead our lives such as work, income and housing;
- physical health including long-term conditions such as diabetes and high blood pressure;
- mental health and wellbeing; and
- the major 'lifestyle behaviour' public health issues such as obesity, healthy eating, smoking and alcohol consumption.

Adulthood is shaped by how we have grown up and shapes how we will live in old age. Improving public health so that all adults are *living well* is a great challenge, particularly in the current climate of public sector cuts. However, there are also opportunities for the people of Cumbria to work together and to develop and utilise assets that already exist within their communities.

This summary report highlights some of the most important findings from the main *Living Well in Cumbria* report which is free to download from NHS Cumbria, the Cumbria Intelligence Observatory, the North West Public Health Observatory and the Centre for Public Health, at Liverpool John Moores University.

Cumbria's changing demography

In 2008, over half (52.8%) of the population in Cumbria were aged between 25 and 64 years (262,010 adults). Over the next twenty years, to 2031, there is an expected overall increase in the population. The number of adults aged 25 to 64 is, however, set to decline during this period (by an estimated 1,000 people) as the county continues to see an increase in older people. **Cumbria will have a larger decrease in the adult population by 2031 than England (declines of 11.7% and 7.0% respectively).**

Cumbria has a lower proportion of the population living in the most and least deprived areas compared to the rest of England,[A] with just over half of the adults in Cumbria living in the third and fourth most deprived areas (28.2% and 24.4% respectively).

Work, health and wellbeing

Being in good quality employment – secure, well-paid and personally rewarding work – is generally good for our health whereas being out of work due to unemployment or incapacity contributes to poor health. Among the working age population there is a clear social gradient, with certain groups of people, for example those with higher levels of educational qualifications and skills, much more likely to be in good employment than other groups. Those with no or few qualifications or people with disabilities and ill health will invariably experience higher rates of unemployment or incapacity.[1,2] Long-term unemployment or incapacity is likely to be particularly damaging to people's sense of wellbeing because they are more likely to feel excluded from what are the normal routines of life for working people and addressing these issues is a high priority for welfare reform.[3]

The working age population of Cumbria was 295,027 people in 2008 of whom 238,800 (81.0%) were economically active, some 4.7% higher than the North West and 2.1% more than for England. Consequently, Cumbria had a lower proportion of the working age population that was economically inactive (19%) compared to the regional (23.7%) and national (21.1%) levels. **Cumbria's employment rate (78.6%) was also higher than for the North West (71.3%) and England (74.2%) and the county's unemployment rate at 2.9% was less than half the regional (6.5%) and national level (6.0%). However, the 7,000 people who were registered as unemployed in Cumbria at this time were looking for work in a county that had only 2,180 notified vacancies.** Among the economically inactive population of 56,200, approximately three-quarters (42,900) did not want a job but a further 13,300 people wanted a job but did not count as being unemployed. **Average gross weekly pay in Cumbria during 2009 was £465.30 per week, slightly higher than the North West (£460.20) but lower than the England average (£496.00).**

The damage that long-term unemployment causes to people's health and the communities in which they live is severe and has to be addressed if we are to improve the wealth and health of the county.

[A] Lower super output areas are categorised into one of five groups (quintiles) depending on their multiple deprivation score in the Index of Multiple Deprivation 2007. The Index of Multiple Deprivation consists of seven domains covering income, employment, health and disability, education and training, barriers to housing and services, crime, and the living environment. The higher the Index of Multiple Deprivation score, the greater the deprivation experienced by the population.

Definitions of labour market status

- **Working age population:** males aged 16 to 64 years and females aged 16 to 59 years.
- **Economically active:** all people working in the week before the labour market census and people who were not working but were looking for work and were available to start work within two weeks. Full-time students who are economically active are included in this group.
- **Economically inactive:** people who are retired, students (excluding those who were economically active), looking after family/home, permanently sick/disabled etc. A person who is looking for work but is not available to start work within two weeks is economically inactive.
- **Employment rate:** the number of people in employment expressed as a percentage of the resident working age population.
- **Unemployment rate:** unemployed people as a percentage of the economically active population.
- **Want a job:** people not in employment who want a job but are not classed as unemployed because they have either not sought work in the last four weeks or are not available to start work.
- **Do not want a job:** people who are neither in employment nor unemployed and who do not want a job.
- **Notified vacancies:** vacancies notified to Jobcentre Plus that are unfilled; they form a part of the vacancies throughout the economy of the local area.

NOMIS official labour market statistics, Office for National Statistics, 2010

Sickness and disability

The number of people of working age who are economically inactive due to long-term sickness or disability has substantially increased in the past 30 to 40 years. Around 2.6 million people of working age in Britain currently receive incapacity-related benefits[B] for being out of work. This group constitutes about half of all out of work benefit claims by people of working age compared to around 1.5 million people who are unemployed and claiming Jobseekers Allowance.[4]

Central government repeatedly tried to address this issue including reform of the benefits system and programmes to assist people who are sick or disabled to move off benefits and into work.

In October 2008 Employment and Support Allowance replaced Incapacity Benefit for all new claimants complete with a new medical assessment – the Work Capability Assessment. All existing Incapacity Benefit claimants who will not reach state pension age by 2014 will undergo the Work Capability Assessment, about 1.8 million people, between 2011 and 2014. Those people who are deemed too sick or disabled for work will receive Employment and Support Allowance and an individually tailored support programme to return to work while people who are considered to be capable of some form of work will be moved on to Jobseekers Allowance which is set at a somewhat lower level. The Jobseekers Allowance

[B] Incapacity Benefit, Severe Disablement Allowance, and Employment and Support Allowance are three of the main benefits for people of working age who are sick or disabled. At the time of writing this report there were not yet any detailed proposals for reform of the benefit system although the introduction of a simplified system of credits at some point in the future appears to be likely.

is designed for people who are ready for work so there is a real risk that people with long-term health conditions will not receive the help and support that they need in order to sustain a return to work.[5] These policy developments point toward a need for an appropriate and concerted effort to assist and support people with long-term health conditions back into the labour market in Cumbria in the next few years.

In June 2010 around 6.5% of the working age population were claiming incapacity benefit across Cumbria slightly higher than for England (5.6%). There were wide variations in the proportion of claimants across the county's local authority districts, for example 10.9% of males in Barrow-in-Furness received incapacity-related benefits compared to 3.6% of females in South Lakeland (Figure 1).[C] Claims for incapacity-related benefits due to mental illness were slightly higher in Cumbria (30.4 per 1,000 working population) than England (27.6 per 1,000 working population), with large differences across the county.

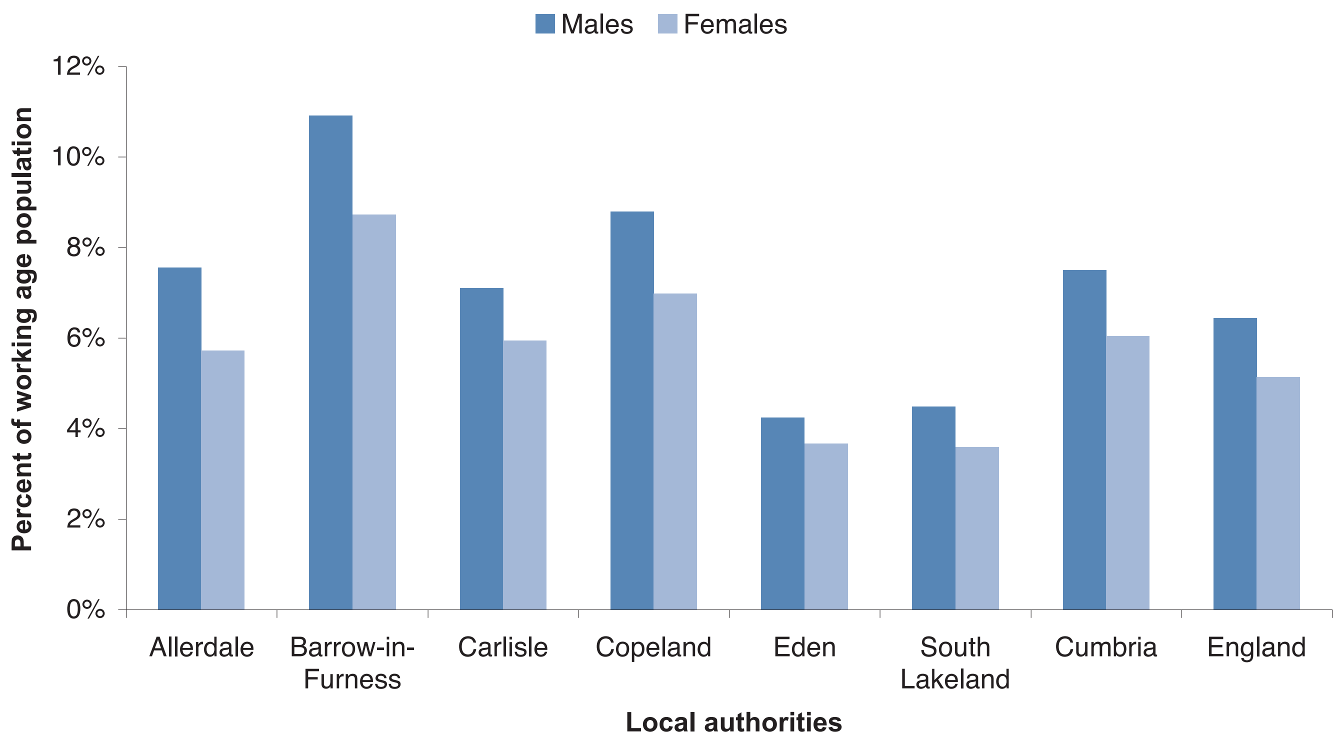
The relationship between chronic sickness or disability and deprivation is likely to run both ways - long-term sickness and disability contributes to deprivation and deprivation contributes to long-term sickness and disability - and the scale of the challenge to be addressed is considerable. Unsurprisingly, it is the most deprived areas of the county that have the greatest concentration of people claiming benefits due to long-term sickness or disability. In Cumbria the claimant payment ratio[D] for claimants of Incapacity Benefit and Severe Disablement Allowance in the most deprived fifth of areas was 243.1 in 2009, more than five times greater than the level in the least deprived fifth of areas at 47.5 (Figure 2).

A healthy labour market that provides opportunities for people to secure and retain purposeful, paid work will provide considerable economic, health and social benefits for individuals and communities. Tackling the causes of long-term sickness and disability is an essential part of this task and the greatest efforts need to take place in the most deprived communities where the problems are often the most severe. We need to develop a greater degree of security and flexibility in employment and the benefits system so that no communities are left to be blighted by ill health and deprivation. We need to encourage local initiatives that support people who are long-term sick or disabled to make the transition into paid work and to improve the number and quality of jobs so that work-related ill health is reduced.

[C] Throughout the report, 95 per cent confidence intervals have been included wherever possible and are shown as 'whiskers' on charts.

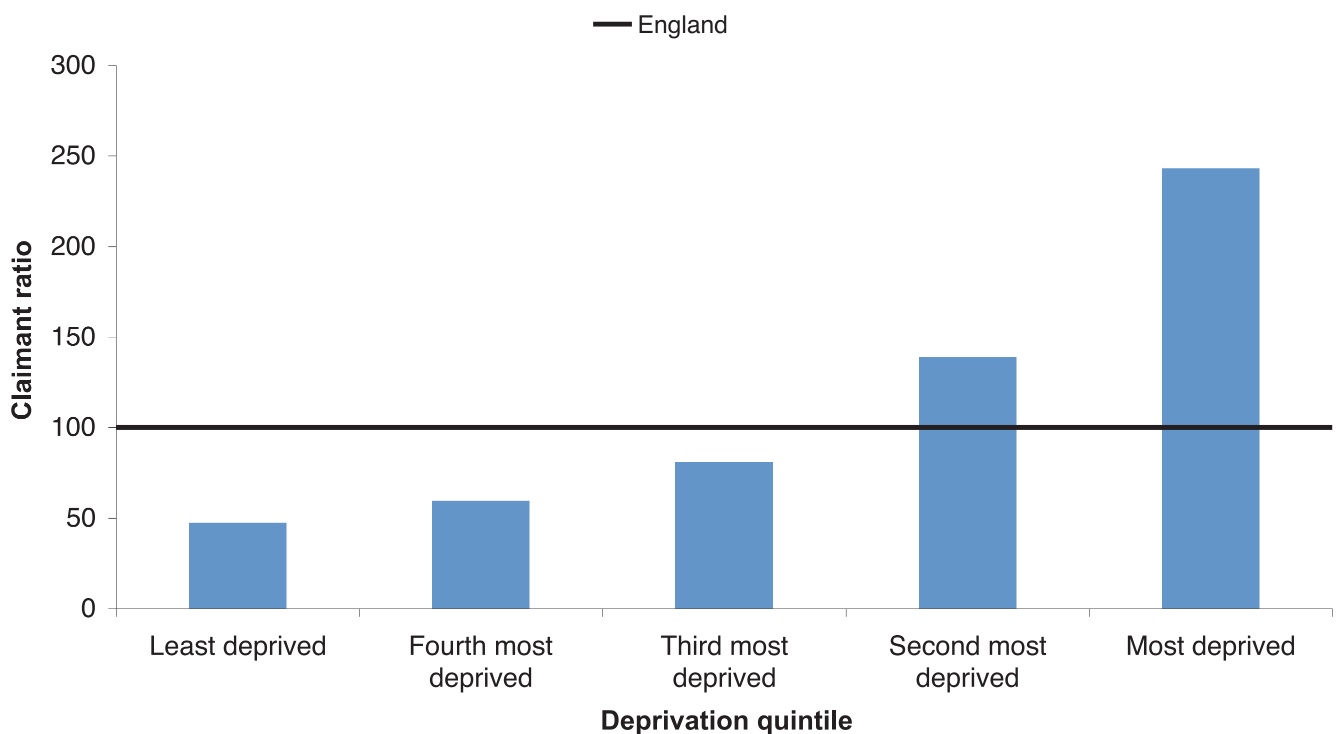
[D] Standardised claimant ratios express the total number of claimants in one population against that in a 'standard' population, while allowing for differences in their age structure. Here incapacity benefit claimants in England in a given year have been used as the standard population to give an age-standardised ratio of 100. Areas with a greater number of claimants than expected (if the claimant numbers by age for England were applied to their population) have a standardised claimant ratio greater than 100. In contrast, areas with fewer claimants than expected have a standardised claimant ratio below 100.

Figure 1: Proportion of working age population claiming Incapacity Benefit/Severe Disablement Allowance[E] by local authority and gender. Cumbria, June 2010.



Source: NWPHO from Office for National Statistics (NOMIS).

Figure 2: Claimant payment ratio of working age population by Index of Multiple Deprivation 2007. Cumbria, 2009.



Source: NWPHO from Office for National Statistics (NOMIS).

[E] Severe Disablement Allowance is a benefit for people who are unable to work as a result of a long term severe illness or disability but have not paid sufficient National Insurance contributions to qualify for Incapacity Benefit. See www.dwp.org.uk for more information.

Financial security

Financial security, achieved by most people by engaging in paid work, is a major influence on mental health and wellbeing. For adults of working age, being worried about money is one of the key differences between people with differing levels of wellbeing although it is a consistent concern across all groups. In Cumbria, people of working age with above average levels of wellbeing were much more likely to never have worries about money (54.0%) compared to those with average (39.2%) or below average (14.6%) levels of wellbeing (Table 1). Conversely, people with below average levels of wellbeing were more likely to be worried about money almost all the time (9.7%) compared to people with average (5.2%) or above average (5.1%) levels of wellbeing.

Table 1: Worries about money by level of mental wellbeing. Cumbria, 2009.

Mental wellbeing	Almost all the time (%)	Quite often (%)	Only sometimes (%)	Never (%)
Below average	9.7	19.8	55.9	14.6
Average	5.2	18.9	36.8	39.2
Above average	5.1	12.2	28.7	54.0

Source: NWPHO from Cumbria Mental Wellbeing Survey 2009.

Concerted efforts are required across Cumbria to improve access to secure, well paid and rewarding jobs that promote health and to reduce long-term unemployment and inactivity that damages health. Communities where people are already disadvantaged in the labour market through lack of skills or ill health must be the focus of these efforts. Employers must be encouraged to create flexible jobs for people with caring responsibilities and health problems that inhibit their ability to work long hours. Most importantly, new jobs need to be sustainable in economic, social and environmental terms. We need to make a distinctly Cumbrian contribution to creating new 'green jobs' that promote environmental and economic sustainability and provide greater opportunities for wealth and health.

Housing

Housing conditions have a significant influence on health and wellbeing and ensuring that people live in good quality, affordable housing is important to the social sustainability of neighbourhoods and the environment.[6,7,8,9,10]

Affordability, availability of social provision and the quality of housing are all issues that need to be addressed to improve the position in Cumbria. The issue of housing affordability is complex, requiring an increase in housing supply, specifically in affordable homes (such as sale or discounted housing and shared equity schemes) including social and supported housing.

The extent of often insecure and low wage service sector jobs limits housing options for many people, and there is a justifiable fear that limited opportunities for young people will lead to them leave the county while older people move into the area. With the ageing of the population, we also need to prepare for 'lifetime homes' that people will be able to stay in for as long as they wish during their old age, with the provision of health and public services 'closer to home' across the county.[11,12]

Four main priorities from the Cumbria Housing Strategy 2006/11

- Affordable Housing – providing affordable homes to maintain balanced communities;
- Creating Decent Homes – delivering decent homes in thriving neighbourhoods;
- Regeneration – urban renaissance and dealing with changing demands; and
- Homes with Support or Additional Facilities – meeting the regions needs for specialist and supported housing.

Cumbria Sub Regional Housing Group, 2006

Average house prices in Cumbria are some way below the average for England and while average household incomes are lower than in the rest of the country, the affordability ratio of mean income to average house price is slightly lower. House prices in Barrow-in-Furness are the lowest in the county, approximately half the level in Eden and South Lakeland. The lowest affordability ratio in the county (4.1) is in Barrow-in-Furness and Copeland, while Eden and South Lakeland have house prices and affordability ratios well above the national average (Table 2).

Table 2: House prices, household income and affordability. Cumbria and England, 2010.

Area	Mean house price (£)	Mean household income in area (£)	Affordability Ratio
Allerdale	160,955	30,818	5.2
Barrow-in-Furness	115,572	28,013	4.1
Carlisle	149,485	31,696	4.7
Copeland	130,871	31,810	4.1
Eden	227,127	32,053	7.1
South Lakeland	245,756	33,338	7.4
Cumbria	**172,547**	**31,410**	**5.5**
England	**209,130**	**35,299**	**5.9**

Source: NWPHO from Cumbria Intelligence Observatory.

The majority of households in Cumbria and England are owner-occupiers, around 70% of all households,[13] but given the difficulties in getting a foot on the property ladder the need for accessible, affordable social housing continues to be a pressing need.

Cumbria must continue to move towards all homes meeting the standards for Decent Homes (Housing, Health and Safety Rating System) introduced in 2006.[14] The majority of properties in Cumbria fail the Decent Homes Standard (using the Standard Assessment Procedure[F]) for energy efficiency because of thermal inefficiency in terms of ventilation and heating.[11] This deficiency in the housing stock has long-term economic, environmental and health costs in terms of higher energy bills, carbon footprints and excess winter deaths among older people. While there have been improvements in the social housing stock meeting these standards in the last few years, it is essential that private sector housing also meets them.

Health and mental wellbeing

At the end of the first decade of the twenty-first century, health and wellbeing is a somewhat mixed picture with some indicators showing continuing improvement while others are worsening. **We are living longer than we have ever done; in 2008 average life expectancy in Cumbria was 77.8 years for men and 81.4 years for women.**[G]

Being mentally healthy does not simply mean that you do not have a mental health disorder, such as anxiety or depression, but it is about how you feel and function on a daily basis. There is an individual dimension to wellbeing that involves how we feel about ourselves both now and in the future and there is also a social dimension that includes the neighbourhood where we live and our views on wider society.

Good mental health is characterised by a person's ability to fulfil a number of key functions and activities, for example:

- The ability to learn;
- The ability to feel, express and manage a range of positive and negative emotions;
- The ability to form and maintain good relationships with others; and
- The ability to cope with and manage change and uncertainty.[15]

Health and mental wellbeing are closely linked and evidence shows that individuals with good mental wellbeing have a higher satisfaction with life and are much more likely to be in employment, be educated, be healthy and have closer relationships with others. In 2009, a large scale regional survey – the *North West Mental Wellbeing Survey*[16] – produced a wealth of data on the health and wellbeing of the population across a range of dimensions. It allows comparisons to be made between Cumbria and the rest of the North West region as well as analysis within the county. The survey used the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) which contains seven items:

- I've been feeling optimistic about the future;
- I've been feeling useful;
- I've been feeling relaxed;
- I've been dealing with problems well;
- I've been thinking clearly;
- I've been feeling close to other people; and
- I've been able to make up my own mind about things.

[F] The Standard Assessment Procedure: is the energy cost rating as determined by the Government's Standard Assessment Procedure (SAP) and is used to monitor the energy efficiency of homes. It is an index based on calculated annual space and water heating costs for a standard heating regime and is expressed on a scale of 1 (highly inefficient) to 100 (highly efficient with 100 representing zero energy cost). The method for calculating SAP was comprehensively updated in 2005.

[G] Life Expectancy at birth 2006 to 2008.

Responses are used to produce a score ranging from seven to 35. This score is used to group people into having either a low, moderate or high level of wellbeing.

The mean average Warwick-Edinburgh Mental Wellbeing Scale score for the 3,000 adults (aged 16 to 85 years) who participated in the survey across Cumbria was 26.70, lower than the regional average of 27.70. The distribution of scores across the North West was also used to categorise people's level of mental wellbeing as low, moderate or high.[H] **The Cumbrian sample had a higher proportion of people with a low level of mental wellbeing than the regional average (24.2% compared to 16.8% in the North West) and a lower proportion of people with a high level of mental wellbeing (14.9% in Cumbria compared to 20.4% in the North West).**

Self-assessed good health

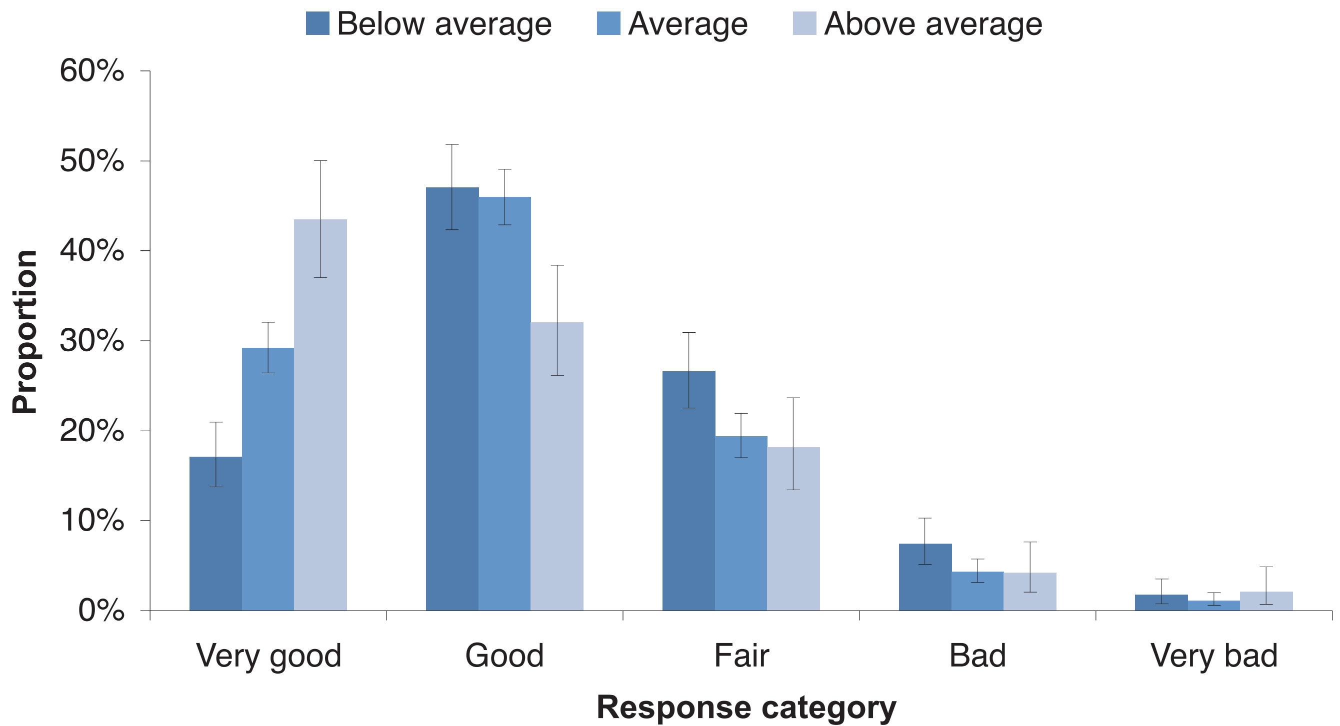
Looking at **self-assessed general health among survey respondents aged 25 to 64, the majority (72.3%) reported having very good or good health compared to 6.7% having bad or very bad health** (Figure 3). Those with an above average level of wellbeing were more likely to consider their health to be very good or good (75.6%) than those with below average wellbeing (64.2%). Among those with below average wellbeing, 9.2% reported bad or very bad health.

Of the sample who had a below average level of wellbeing, Eden (44.7%) and Carlisle (40.9%) had the largest proportion, with narrow differences seen between the other four local authority districts (Allerdale, Barrow-in-Furness, Copeland and South Lakeland). Eden (48.5%) and Carlisle (50.2%) had the lowest proportions of average wellbeing while the remaining districts had a fairly even distribution. South Lakeland had by far the largest proportion (27.5%) of people with above average wellbeing. There were no significant differences in wellbeing by age group. The proportion of people with below average wellbeing is slightly higher for adults aged 40 to 54 (25.9%) and 55 to 64 (27.6%) years.

Life satisfaction is an important part of mental wellbeing along with other factors such as relationships and trust in other people. Almost two-thirds of those who were dissatisfied with life reported below average wellbeing (61.5%) (Figure 4).

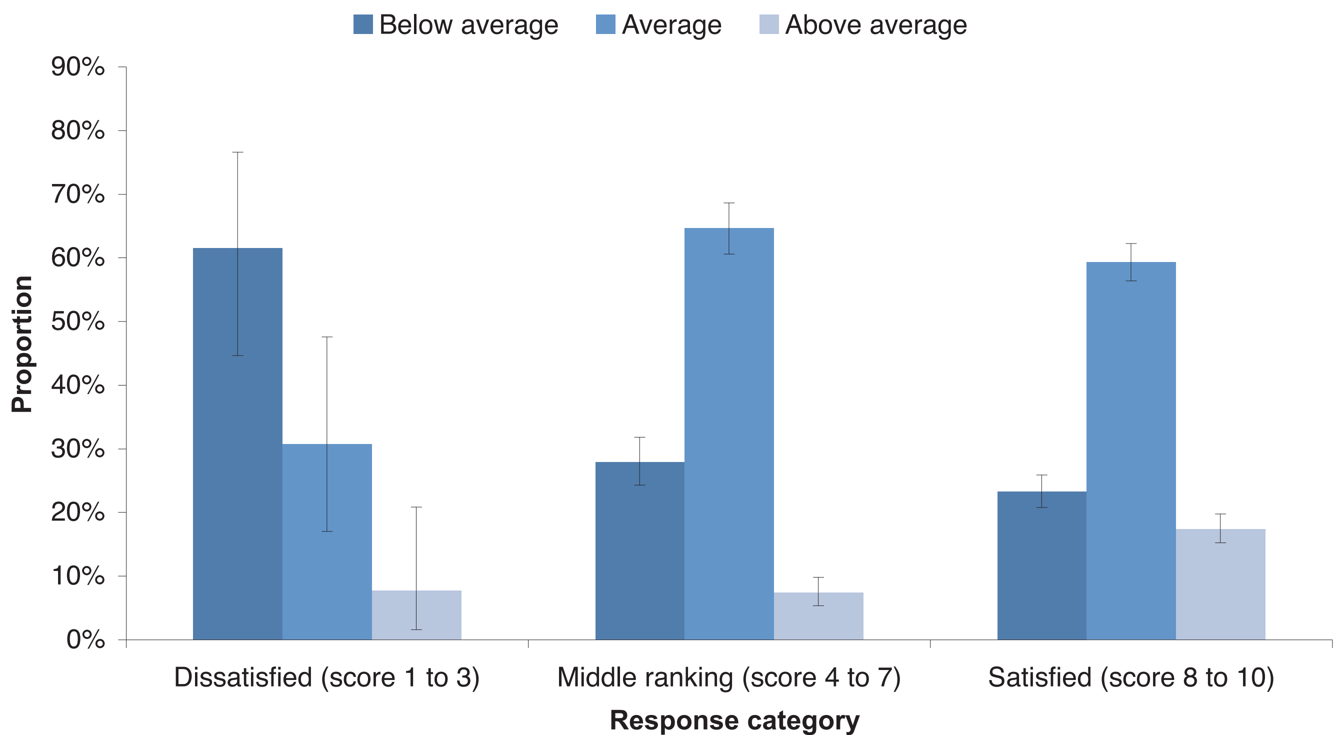
[H] High, moderate and low levels of mental wellbeing are defined as having a WEMWBS score that is one standard deviation above or below the mean.

Figure 3: Self-assessed general health by level of mental wellbeing. Cumbria, 2009.



Source: NWPHO from Cumbria Mental Wellbeing Survey 2009.

Figure 4: Life satisfaction category by level of mental wellbeing. Cumbria, 2009.



Source: NWPHO from Cumbria Mental Wellbeing Survey 2009.

Improving the mental health and wellbeing of the whole population of Cumbria over the whole of the life-course is a task that requires us all to work together to improve the conditions of daily life for all. For adults of working age that means improving wellbeing in the workplace and in neighbourhoods. In our day to day lives in communities across the county we can all make a difference to our mental health and wellbeing and that of our neighbourhood by following the 'five ways to wellbeing' based on the latest evidence.

'Five ways to wellbeing'

1. **Connect**… With the people around you. With family, friends, colleagues and neighbours. At home, work, school or in your local community. Think of these as the cornerstones of your life and invest time in developing them. Building these connections will support and enrich you every day.
2. **Be active**… Go for a walk or run. Step outside. Cycle. Play a game. Garden. Dance. Exercising makes you feel good. Most importantly, discover a physical activity you enjoy and that suits your level of mobility and fitness.
3. **Take notice**… Be curious. Catch sight of the beautiful. Remark on the unusual. Notice the changing seasons. Savour the moment, whether you are walking to work, eating lunch or talking to friends. Be aware of the world around you and what you are feeling. Reflecting on your experiences will help you appreciate what matters to you.
4. **Keep learning**… Try something new. Rediscover an old interest. Sign up for that course. Take on a different responsibility at work. Fix a bike. Learn to play an instrument or how to cook your favourite food. Set a challenge you enjoy achieving. Learning new things will make you more confident as well as being fun.
5. **Give** … Do something nice for a friend, or a stranger. Thank someone. Smile. Volunteer your time. Join a community group. Look out, as well as in. Seeing yourself, and your happiness, as linked to the wider community can be incredibly rewarding and creates connections with the people around you.

Mental Capital and Wellbeing: Making the most of ourselves in the 21st century
Foresight Report, 2008

Developing sustainable, connected communities by promoting social capital and social networks through volunteering, increasing access to green spaces, starting or joining a community group or sports club all contribute to promoting mental health and wellbeing.[17] In Cumbria, we have resilient communities, especially during times of crisis, which are nationally recognised and admired for the civic virtue and the spirit of looking out for one another.[18] We can build on this enormous strength if we work together – a Cumbrian approach to co-production – to enhance the quality of life for people across the county and we will reap the benefits in terms of better public health.

Another potential benefit of improving mental health and wellbeing could be a reduction in the increasing demand for primary care and prescription medications. **There are in excess of three million consultations within the 92 General Practices across Cumbria each year.**[19] As in England, the most commonly prescribed drugs in Cumbria are for hypertension and heart disease, cholesterol regulating lipids, anti-depressants and drugs for diabetes. Prevention of the chronic conditions that require these often long-term pharmacological interventions is one of the aims of public health and can best be achieved with people who are fully engaged with leading a healthy lifestyle.

Chronic conditions

In England, almost a third of the population, in excess of 15 million people have a long-term health condition. These people are living with physical or learning disabilities or mental health problems such as depression (more than twice as common among people with chronic physical health problems) and require care over many years. An estimated 75% of people over the age of 75 years are living with at least one long-term condition. Many of these problems start during our 'working years' due to chronic conditions such as hypertension (high blood pressure) and diabetes. Better management of people with long-term conditions in the community is an essential part of contemporary public health care. Given that people living with long-term conditions account for more than half of all GP appointments and nearly two-thirds of all hospital outpatient appointments[20,21] it is important to reduce their incidence and enable people to effectively self care.

Some long-term conditions, such as hypertension and high cholesterol, can be managed to such an extent that the affected individual can return to normal through a combination of medication and lifestyle change. Other long-term conditions are not amenable to change; once a person has developed diabetes or arthritis they have it for the rest of their life. There are different approaches to managing long-term conditions including disease management that monitors the at-risk population and intervenes at an early stage to meet needs; case management identifies vulnerable individuals and builds care around them; and self care that aims to enable individuals and carers to develop the confidence and knowledge to manage their own condition. Self care is about looking after yourself in as healthy a way as you can with the support of NHS health care professionals in order to improve your quality of life. There is a growing body of research that suggests that people with long-term conditions who take more control of their health have a much better quality of life.[22,23] We need to be developing appropriate care pathways to promote self care for as many people who can benefit from it across the county.[24,25]

Vascular diseases

Hypertension or high blood pressure, is usually defined as having a sustained blood pressure of 140/90mmHg or above.[26] It is an important modifiable risk factor in early deaths and long-term limiting illness due to circulatory conditions such as heart disease and stroke; reducing the

number of people with hypertension means fewer people are likely to develop chronic vascular conditions in the future. Prevalence of hypertension is considerable with 13% of adults registered with a GP in England in 2008/09 (around seven million people) having been diagnosed with the condition. The best way to prevent hypertension is to lead a healthy lifestyle based on eating a balanced diet, maintaining a healthy weight and being physically active. Drinking large amounts of alcohol and smoking are also associated with developing hypertension and should be avoided for this and a wide variety of other health reasons.

Cholesterol is a fatty substance known as a lipid that is needed for the body to function properly and is produced by the liver from the fatty foods that we eat. Having an excessively high level of lipids (hyperlipidemia) increases the risk of having a heart attack or stroke, particularly in combination with hypertension.

The widespread use of prescription medication to treat hypertension and high cholesterol has been successful and these pharmacological interventions are estimated to save in excess of 6,000 lives in England every year.[27] However focusing on the symptoms of groups of people who are at high risk of circulatory disease is hardly a comprehensive public health strategy.[28] We need to develop asset based community solutions[29] and population based strategies that reduce the risk of cardiovascular disease for everybody rather than focusing predominantly on those at the highest risk. Population and individual based approaches are both important and can be complementary in the prevention of cardiovascular disease and we need to have both approaches in Cumbria.[30]

In 2007/08, there were 73,825 adults in Cumbria on a GP register for hypertension. This is a slightly higher proportion than the North West region and the rest of England and the number of people with hypertension are increasing every year. Given that it is highly likely that there are many more thousands of adults who have the condition but are not being treated for it, this slightly higher proportion of the population on the GP register should be seen as both a warning sign of future health problems and of the progress that has so far been made in diagnosing people.

Diabetes

Diabetes is a long-term condition caused by having too much glucose (a type of sugar) in the blood. The amount of sugar in our blood is controlled by insulin, a hormone produced by the pancreas, which helps to move glucose from the blood and into cells where it is broken down to produce energy. Type 1 diabetes is when the pancreas does not produce any insulin and Type 2 diabetes is when not enough insulin is produced or when the body's cells do not react to insulin; about 90% of all adults with diabetes have Type 2 diabetes.

More than two million adults in England have been diagnosed with diabetes but it is estimated that there are a further 500,000 people who have the condition but are not aware of it.[31] The main symptoms of diabetes are feeling very thirsty, going to the toilet frequently, feeling very tired and weight loss. There is no cure for diabetes and it is a progressive condition (gets worse over time) but it can be managed through changes in lifestyle and medication.[31,32] The risk of developing diabetes is around 20 times greater in the very obese (those with a body mass index of over 35) than in people with a body mass index of between 18 and 25. The exact causes of diabetes are not fully understood but losing 5% of your body weight and taking regular exercise can reduce your risk of developing diabetes by 50%.

People with Type 2 diabetes can control their symptoms by eating a healthy diet, being physically active and monitoring their blood glucose level.

Medication can also help to control the level of blood glucose as part of this lifestyle and it is important that people with diabetes take good care of their own health through self care and review their status with clinicians on a regular basis.

While Cumbria has a similar proportion of adults recorded with diabetes as the rest of England (4.15% compared to 4.3%), there are differences in the prevalence of the condition within the county. Eden had a significantly lower prevalence of diabetes compared to the average for England as did Barrow-in-Furness, Carlisle and South Lakeland while prevalences in Allerdale and Copeland were both significantly higher.

It is estimated that by 2025, there will be more than four million people with diabetes in the UK. If this forecast is realised and Cumbria continues to follow the national trend, we can expect to have more than 32,000 people with diabetes in the county by this time placing considerable additional demands on the NHS.

Preventing diabetes is clearly a priority for public health and will largely be achieved through reducing the prevalence of obesity and increasing the level of physical activity among adults. Providing education programmes to people with diabetes is an essential part of effective long-term care. The diabetes education and self management for ongoing and newly diagnosed (DESMOND) programme consists of group sessions with people recently diagnosed with Type 2 diabetes facilitated by a health care professional. The programme allows attendees to discover more about their condition and how they can set goals to change their lifestyle behaviour in order to have better self care and management of it. NHS Cumbria has been providing DESMOND to patients with diabetes since 2009. Research has shown that the DESMOND programme is likely to be cost effective in terms of incremental costs and quality adjusted life years because of the reductions in weight and smoking that it delivers.[33]

Lifestyle behaviours

Important though lifestyle behaviours and decisions are to health it would be a mistake to think that public health can be improved by addressing these behaviours alone. The underlying social determinants of health such as education, the environment, income and social opportunities and status that all influence decisions need to be addressed.[34] If we do not face up to the range of issues that revolve around obesity, healthy eating and physical activity then we will store up health and social problems for the future.

Obesity

In England in 2008, almost a quarter of all adults, 24% of men and 25% of women aged 16 years and over, were classified as obese using the Body Mass Index [I] and a further 37% were overweight (42% of men and 32% of women).[35] The Body Mass Index is a useful indicator of weight and health status but the distribution of adipose tissue (body fat) also needs to be considered as excess fat around the major organs of the body, most easily measured by raised waist circumference, is particularly harmful to health.

A social gradient in obesity is evident, with a 2004 study revealing the prevalence of obesity among men in Social Class I (professionals) as 18% but in Social Class V (manual workers) some 28% of men were obese. Among women the gap is even wider, with 10% prevalence for Social Class I compared to 25% for Social Class V.[36]

The Foresight report on obesity predicts that by 2015 some 36% of men and 28% of women will be obese rising to 47% of men and 36% of women by 2025.[36] Looking into the distant future with a greater degree of uncertainty, Foresight forecast that by 2050 some 60% of men and 50% of women could be obese. The disease burden forecast for obesity-related conditions in 2050 included a 23% rise in the prevalence of stroke, a 34% increase in hypertension, a 44% rise in heart disease and a 98% increase in diabetes.[37]

The health risks of overweight and obesity

- Ten per cent of all cancer deaths among non-smokers are related to obesity;
- The risk of Coronary Artery Disease increases 3.6 times for each unit increase in Body Mass Index;
- 85 per cent of hypertension is associated with a Body Mass Index greater than 25;
- The risk of developing Type 2 diabetes is about 20 times greater for people who are very obese (Body Mass Index over 35), compared to individuals with a normal Body Mass Index of between 18 and 25; and
- Up to 90% of people who are obese have fatty liver. Non-alcoholic fatty liver disease is projected to be the leading cause of cirrhosis in the next generation.

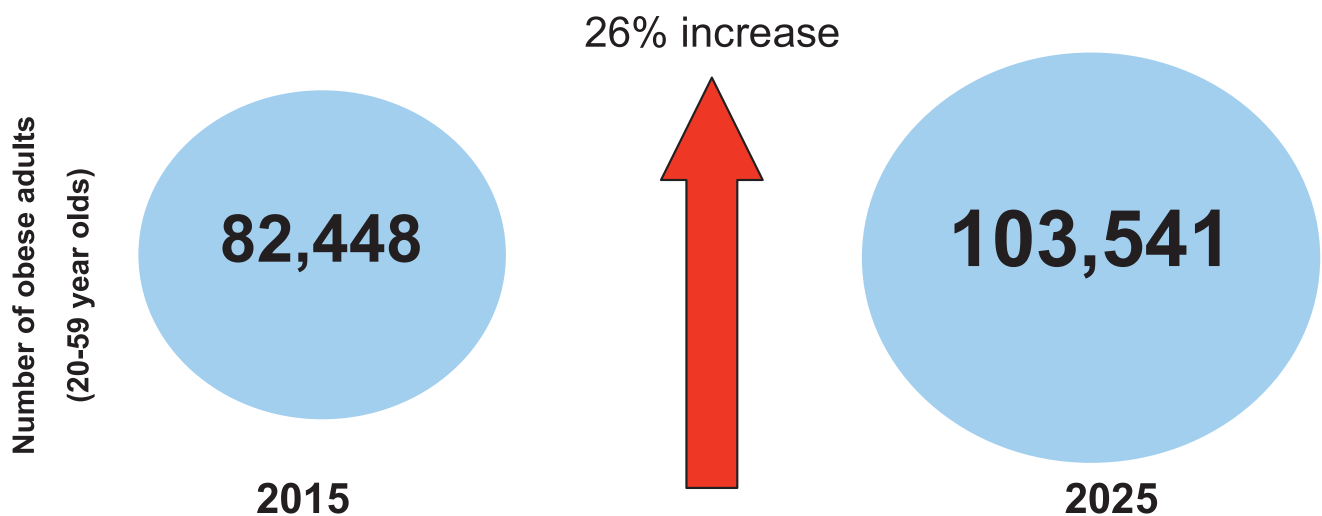
Healthy weight, Healthy lives: a cross-government strategy for England, 2008

The most recent modelled estimates of the prevalence of obesity show that Cumbria has a lower proportion of adults who are obese (23.2%) compared to the rest of England (24.0%) although there are considerable variations within the county. Barrow-in-Furness (26.9%) and Copeland (26.8%) had the highest proportion of obese adults while Eden (20.6%) and South Lakeland (19.3%) had the lowest. **There were approximately 95,200 adults aged over 16 years who were obese in Cumbria,** a number that has increased rapidly over the last 15 years and shows no sign of stopping. Failure to halt the prevalence of obesity will store up health problems for the future.

I Obese is defined as having a Body Mass Index (BMI) of 30kg/m^2 or more while being overweight is defined as having a BMI of 25kg/m^2 or more but below 30. People with a BMI of 40kg/m^2 are defined as morbidly obese.

Applying the original Foresight forecasts for adults in England in the 21 to 60 years age range to the forecasts of the Cumbrian population aged 20 to 59 years in 2015 and 2025, highlights the scale of the challenge ahead (Figure 5).This will contribute to higher rates of chronic illness associated with obesity placing greater strain on people's health and the ability of the NHS to meet their needs. Although this forecast is a highly likely scenario based on past trends and current behaviour, it is not inevitable. Steps can be taken to change this trend at an individual, neighbourhood and national level – and steps must also be taken in policy terms and literally by being more physically active.

Figure 5: Estimated projection of adult obesity[J] for Cumbria in 2015 and 2025.



Source: NWPHO from NHS Information Centre and Department for Business, Innovation and Skills.

Healthy eating

Eating a balanced diet is essential to long-term health and to reducing the level of obesity in the population. It is important to eat a mixture of starchy foods such as rice and pasta, plenty of fruit and vegetables, some food that is rich in protein such as meat, fish and lentils, and some milk and dairy foods for calcium while avoiding too much fat, salt or sugar. The amount of food consumed – portion control – is also important to maintaining a healthy weight. One of the main public health messages about diet and nutrition in recent years has been the 5 A DAY campaign to increase the proportion of people who eat five portions of fruit and vegetables a day. In England in 2008, some 25% of men and 29% of women reported eating five a day but this was lowest in the North West region with only 20% of men and 25% of women.[35]

Cumbria has a slightly lower percentage of healthy eating adults compared to England (27.3% compared to 28.4%) but there are considerable variations within the county. Barrow-in-Furness (21.1%) and Copeland (21.3%) have a much lower proportion of healthy eating adults than Eden (34.8%) and South Lakeland (33.1% - Table 3).

[J] Adult population here is for 20-59 year olds based on England projection estimates of 21-60 year olds.

Table 3: Modelled estimate of healthy eating adults. Cumbria and England, 2008.

Area	Estimated proportion of healthy eating adults (%)	Number of healthy eating adults (rounded to nearest 100)
Allerdale	27.5%	21,500
Barrow-in-Furness	21.1%	12,300
Carlisle	25.6%	22,000
Copeland	21.3%	12,300
Eden	34.8%	15,000
South Lakeland	33.1%	29,000
Cumbria	**27.3%**	**112,100**
England	**28.4%**	**11,871,700**

Source: NWPHO from Health Survey for England, 2006-08.

Physical Activity

Being physically active rather than sedentary is an important influence on health and wellbeing. Regular physical activity improves levels of cardiovascular fitness while reducing the risk of heart disease (reduce risk by 10%), stroke (reduce risk by 20%), Type 2 diabetes (33-50% lower risk), colon cancer (40 to 50% lower risk) and breast cancer (reduce risk by 30%) as well as osteoporosis that contributes to bone fractures in older age (reduces risk of hip fracture by up to 50%). Being physically active also reduces the risk of depression and can be as effective as medication in its treatment in the longer-term.[38]

The Chief Medical Officer has recommended that adults should perform 30 minutes of physical activity of at least a moderate intensity[K] on five or more days of the week. This can be in one half hour session but should last at least 10 minutes in order to be of benefit.[L] Physical inactivity is common, with more than 60% of the population not meeting these minimum recommendations despite a modest increase in the proportion of adults who reported being physically active.[38] People with a high Body Mass Index are more likely to be sedentary than those with a lower Body Mass Index - and is also an important risk factor for heart disease and stroke.[39]

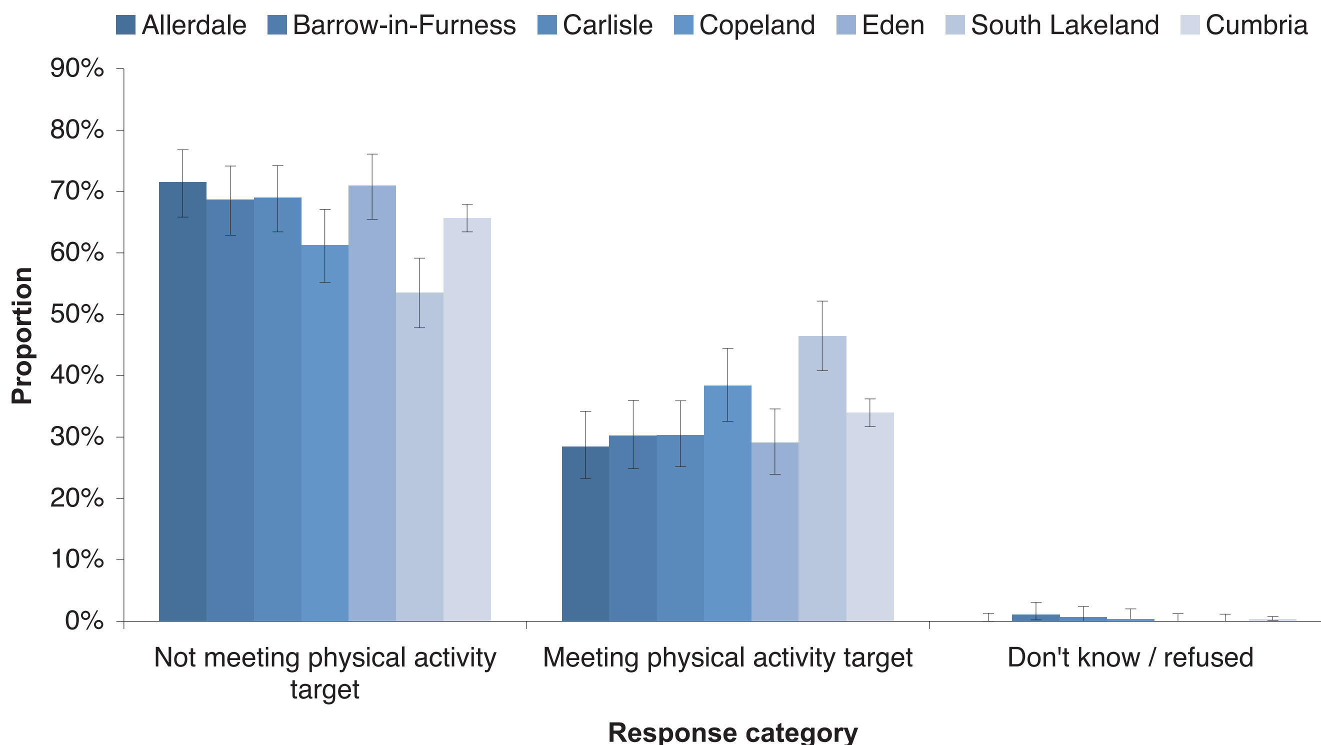
Cumbria had a slightly higher proportion of adults who were physically active (11.5%) than England (11.2%). There were, however, considerable variations within the county with Carlisle having the lowest proportion (9.7%) and Eden the highest (14.1%). In common with reported levels of physical activity from other surveys at a national level, the mental wellbeing survey found that some **66% of people in Cumbria did not meet the recommended level of physical activity** (Figure 6)**. Allerdale (72%) and Eden (71%) had the highest proportion of people not meeting the physical activity target while South Lakeland (46%) had the largest proportion achieving this level of physical activity.** There are approximately 47,400 physically active adults in the county and it must be a priority to substantially increase this number over the forthcoming years.

[K] Moderate intensity physical activity makes individuals breathe heavily and become sweaty and includes heavy housework, gardening, DIY, sports and walking.

[L] The current recommendations are under review as the benefits of physical activity may be more easily achieved if based on a weekly recommendation of 150 minutes of moderate activity (for example three sessions of 50 minutes) or 75 minutes of vigorous activity.

The Cumbria Mental Wellbeing Survey found a significant association between physical activity and mental wellbeing status. A significantly higher proportion of people with below average mental wellbeing did not meet the physical activity target (78.6%) while a significantly higher proportion of people with above average mental wellbeing reported meeting the physical activity target (48.9%).

Figure 6: Physical activity by local authority. Cumbria, 2009.



Source: NWPHO from Cumbria Mental Wellbeing Survey 2009.

Promoting healthier lifestyle choices – healthy weight, healthy eating and physical activity

The issues of obesity, healthy eating and physical activity are distinct but interwoven as they define how individuals lead their lives in so many ways. The number of calories people consume, the balance of their diets and the amount of exercise that they do are all shaped by individual decisions and the environment in which they are taken. It is vital that a lifelong approach to addressing these issues is adopted because there are points in life, such as leaving home or becoming a parent, when people are more likely to make and sustain a lifestyle change around what they eat and how physically active they are. The new approach to public health emphasises the need for behaviour change based on understanding social norms, nudging people to make healthy choices and responsibility at the individual, community and social level.

Policy responses likely to have an impact on the level of obesity

- Increasing walkability/cyclability of the built environment;
- Targeting health interventions for those at increased risk (dependent on ability to identify these groups and only if reinforced by public health interventions at the population level);
- Controlling the availability of/exposure to obesogenic foods and drinks;
- Increasing the responsibility of organisations for the health of their employees; and,
- Early life interventions at birth or in infancy.

Tackling Obesities: Future Choices (Foresight Report) 2007

Cumbria already provides a wide range of opportunities for people to lead a healthier life by losing weight, eating healthier and being more physically active. The *Your Health Counts*[M] initiative provides practical advice and guidance about how to lead a healthier lifestyle while *Active Cumbria*[N] is getting more people, more active, more often, through information on local leisure and sports activities. Each of the local councils in the county provides leisure and sports facilities as well as information on local activities and clubs for people of all ages. Cumbria has some of the most beautiful rural and urban green space in all of England and there are huge benefits for health and wellbeing from using it regularly. Setting up green gyms (restoring a local park or common ground into a community asset) or developing community allotments are options that offer opportunities for healthier lifestyles as well as enhancing skills and self-confidence, boosting communities and also benefiting the environment.[O]

Smoking

Smoking is the nation's single greatest cause of preventable illness and early death from a wide range of causes.[40] Tobacco is a risk factor in six of the world's eight leading causes of death, and deaths from smoking are more numerous than the next six most common causes of preventable death combined; namely drug misuse, road accidents, other accidents and falls, alcohol, diabetes and suicide.[41]

Smoking is one of the greatest causes of health inequality, it is both caused by and a cause of deprivation, leading to a cycle of poverty in health.[42] While there has been steady progress in reducing smoking prevalence over the last decade, with levels falling from 28% to 21% of adults between 1998 and 2008, the gap in prevalence between the most and least deprived in society is continuing to grow. Smoking is a social norm in many disadvantaged communities and providing disadvantaged groups or areas with enhanced provisions and better access to smoking cessation services can only be one element of a broader strategy to address the distribution of the wider determinants of health. All activities need to be developed and sustained on a long term basis in order to increase their effectiveness.[43]

[M] For further information on Your Health Counts see: www.cumbriahealthcounts.nhs.uk

[N] For further information on Active Cumbria see: www.activecumbria.org

[O] Green gyms, of which there are more than 70 across the UK, are run by the British Trust for Conservation Volunteers or are run under licence by other organisations or are self-supporting. For more details see: www2.btcv.org.uk

Smoking is slightly more prevalent among men (21%) than women (20%) and varies considerably by age. Smoking is most common among younger adults in the 20-24 and 25-34 years age range and gradually declines with age. It is essential to reduce the number of young people who start smoking in order to lower the prevalence of adults who smoke in the future.[44]

In 2008/09 some 67% of current smokers reported wanting to quit with 75% reporting having tried to give up in the past.[44] While the desire to quit and access to NHS Stop Smoking Services is relatively equitable across the socio-economic groups there are marked differences in the rate of success of quit attempts. Smokers from more deprived backgrounds are less likely to quit and stay off tobacco and evidence suggests that they are also more physically addicted to nicotine making it more difficult for them to successfully stop smoking.[41]

About half of all quit attempts in England are 'assisted quits' made by people with support from NHS Stop Smoking Services, primary care or using over the counter medication. Quitting with support from NHS Stop Smoking Services is up to four times more likely to result in prolonged abstinence than quitting without assistance. Over four million quit dates have been set with local NHS Stop Smoking Services and there have been over two million successful quit attempts. An estimated 1.4 million life years have been gained by smokers stopping which equates to 70,000 lives being saved over 10 years.[41]

One in five (21.7%) of Cumbria's adult population (over 16 years) smoke, approximately 89,300 adults. This is slightly below the average for England (22.2%) however large variations within the county exist (Table 4). **Carlisle had a significantly higher rate of smoking (26.7%) than all other local authorities, while South Lakeland (17.2%) and Eden (19.4%) had significantly lower rates.**

There were significant differences in the level of hospital admission due to smoking within the county that reflect long-standing patterns in the distribution of smoking. **Copeland and Carlisle had significantly higher rates of hospital admission compared to England while South Lakeland and Eden's rates were significantly lower.**

Table 4: Estimated percentage of adults (aged 16+) who smoke, 2006-08.

Area	Estimated proportion of adults who smoke (%)	Number of adults who smoke
Allerdale	20.9	16,300
Barrow-in-Furness	22.6	13,200
Carlisle	26.7	22,900
Copeland	23.3	13,500
Eden	19.4	8,400
South Lakeland	17.2	15,000
Cumbria	**21.7**	**89,300**
England	**22.2**	**9,875,900**

Source: NWPHO from APHO Health Profiles 2010.

The mental wellbeing survey **estimated smoking prevalence in Cumbria at 28.2% with Barrow-in-Furness having the highest proportion of current smokers (37.3%) followed by Allerdale (33.3%) and Carlisle (30.1%).**

Supporting people to stop smoking is an important part of improving public health in Cumbria given the harm that it does. **Compared to the North West, Cumbria has consistently had a higher proportion of people who set a quit date and successfully achieve this goal. From April 2009 to March 2010, Cumbria had 5,958 people setting a quit date and 3,732 (62.6%) people were successful.** Of the 3,390 women who set a quit date some 2,052 were successful (60.5%) compared to 1,680 (65.4%) of the 2,568 men.

For the period of April to June 2010, the quit rates among males and females in Cumbria were higher than those in the North West and England (Table 5). While many smokers may want to give up the habit, it is a part of life that many people enjoy and this has to be acknowledged in efforts to persuade people to stop smoking.

Table 5: People who stopped smoking. Cumbria, North West and England, April–June 2010.

Area	Males		Females	
	Number	%	Number	%
Cumbria	376	58.1	418	56.2
North West	5,499	46.0	6,220	42.4
England	38,499	48.6	39,751	45.5

Source: NWPHO from The Information Centre.

Promoting healthier lifestyle choices - smoking

Giving up smoking can be very difficult but even brief interventions by health professionals during routine health consultations can be effective in encouraging people to consider and use NHS Stop Smoking services.[45,46] There is strong evidence to support the continuation of tobacco control policy based on increasing taxation to make cigarettes more expensive, national campaigns to persuade people to stop smoking, brief interventions by health professionals and the provision of Stop Smoking services.[47]

In Cumbria, this means continuing to provide advice and guidance to people who smoke, particularly to those who have not been successful in their most recent attempt at stopping smoking. The provision of Stop Smoking services has to be visible and attractive to all smokers who want to quit and there needs to be a balance between the provision of services associated with clinical settings that people attend for other reasons and opportunistic or targeted provision in the community.[48]

It essential to focus public health interventions in those areas and on the groups that have the highest rates of smoking through innovative means. For example, some public health interventions to stop smoking have used incentives and competitions to encourage smokers to stop such as the 'Quit and Win' scheme in parts of Cumbria. This scheme provided free access to leisure centres in Carlisle, Barrow and Dalton to people who were confirmed as having successfully given up smoking for four weeks. Although such schemes may be more effective in the short run in terms of the proportion of people who stopped smoking, the evidence indicates that once the rewards stop the early success dissipates. However, competitions and rewards may attract more people to make an attempt to quit smoking so while such interventions do not have higher cessation rates they can lead to a greater number of people quitting.[49] Experimenting and evaluating local initiatives like 'Quit and Win' as well as raising awareness of Stop Smoking services will all contribute to reducing the prevalence of smoking.

Alcohol

Alcohol-related harm is a global public health problem causing an estimated 2.5 million deaths worldwide per year of which unintentional injuries alone account for around one third.[50] Alcohol is a potentially addictive psychoactive substance linked to a range of health issues such as high blood pressure, mental ill heath, accidental injury, violence, liver disease and sexually transmitted infections.[51] There is increasing evidence that alongside volume of alcohol, drinking patterns are relevant for health outcomes.[52]

More than 90% of adults in England drink alcohol and the majority do so sensibly.[53] However, around 10 million adults consume alcohol at 'hazardous' levels[P] and more than eight million people in England (26% of the population) have an alcohol use disorder.[54] Alcohol misuse not only poses a threat to the health and wellbeing of the drinker, but can also negatively impact on family, friends, communities and wider society through such problems as crime, anti-social behaviour and loss of productivity in the workplace.[55]

[P] The term 'hazardous' has now been superseded by the term 'increasing risk drinking' for the damage to health that excessive alcohol consumption can produce. The term 'harmful' has similarly been supplanted by 'higher risk drinking' although the amount of alcohol units has remained unchanged. 'Increasing risk' means more than three or four units a day on a regular basis for men and more than two or three units a day for women. 'Higher risk' means more than eight units a day, or more than 50 units a week, on a regular basis for men and more than six units a day, or more than 35 units a week, for women.

The North West has the highest rate for alcohol-related hospital stays compared to all other regions.[55] However, there are major inequalities in these health behaviours across the region with people in disadvantaged groups more likely to drink alcohol at levels that increase risks to health. Within localities, individuals with greatest disadvantage have four to fifteen times greater alcohol-specific mortality and four to ten times greater alcohol-specific admissions to hospital than the most affluent.[56] **Allerdale, Barrow-in-Furness, Carlisle and Copeland report hospital admissions for alcohol-related harm that are significantly worse than the England average. Conversely, Eden and South Lakeland are amongst the North West local authorities with the lowest hospital prevalence ratios for alcohol specific conditions.**[57]

The relationship between alcohol misuse and alcohol-related harm in different socio-economic groups is complex. Evidence shows that in general, as the level of gross weekly household income rises, so does alcohol use. However, despite people from higher income households consuming more alcohol, people from lower socio-economic groups are more vulnerable to its negative effects.[58] Gender differences in alcohol consumption also exist with death rates from alcohol-related causes much higher among men than women – a gap that has widened in recent years.

In Cumbria, over 30% of violent crime is recorded as alcohol-related.[59] According to the 2009/10 British Crime Survey, in half of all violent incidents victims believed the offender(s) to be under the influence of alcohol and overall there were 986,000 of these incidents reported.[60] Studies in England and Wales have shown that a fifth of all violence takes place in and around bars and nightclubs, and up to 70% of all Accident and Emergency department attendances on weekend nights are alcohol-related.[61] **Hospital admissions for alcohol-specific reasons, which does not include attending an Accident and Emergency department, were significantly worse than the England average for the local authority areas of Allerdale, Barrow-in-Furness, Carlisle and Copeland.**[62]

Alcohol-related harm can manifest itself in a variety of ways and can have a major impact on the quality of life of many people. Such drinking behaviours are associated with a wide range of health and social problems including anti-social behaviour, road traffic casualties, risky sexual behaviour, unintentional injuries, domestic violence and child abuse. Violence between current and former partners is a considerable public health and criminal justice problem with an estimated 28% of women and 17% of men having experienced such abuse with alcohol being an important factor in such violence.[63] **In Cumbria over 50% of domestic violence victims and offenders are problem drinkers.**[59]

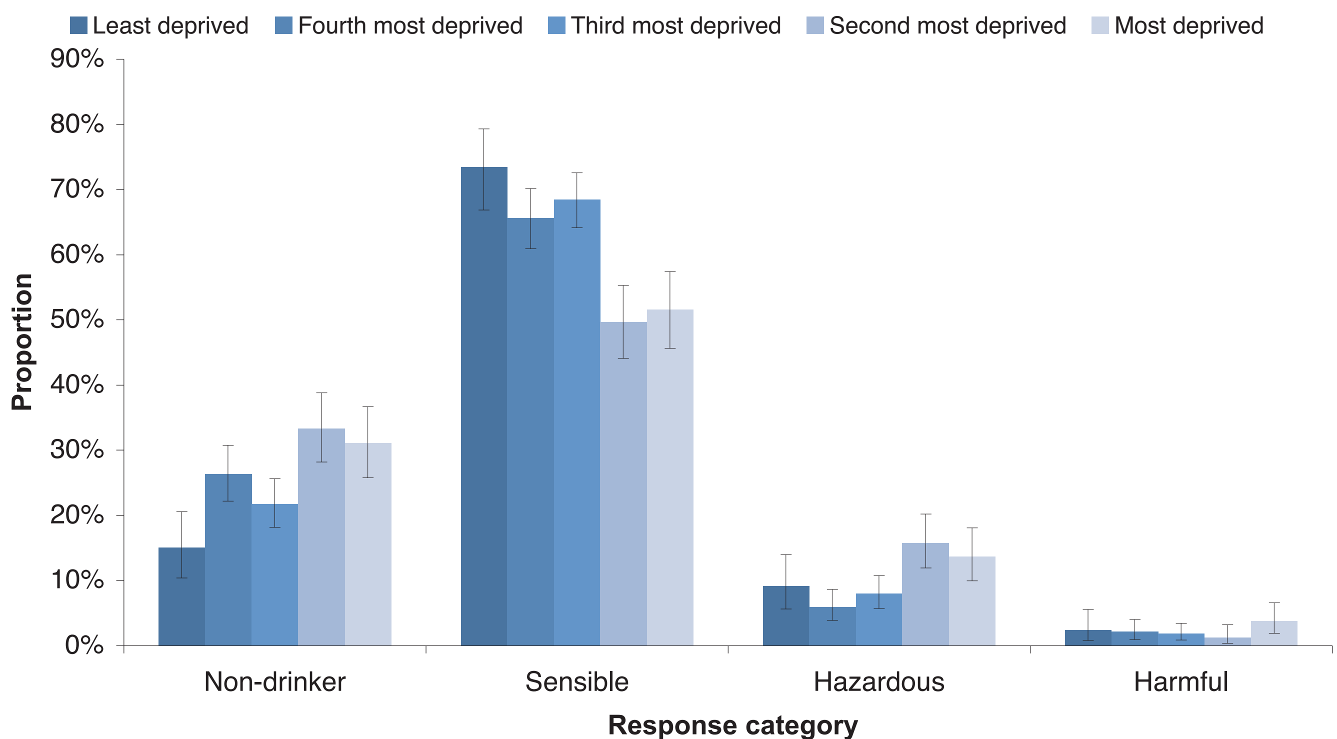
As well as individual and partner alcohol-related harm, other members of families, in particular children, are likely to suffer the negative effects of alcohol. In the Cumbria Alcohol Strategy for 2008 to 2011, *Time to Call Time*, a key objective is to safeguard children and young people, including reducing the harm caused to children by parental alcohol use.[59]

A national strategy to tackle alcohol misuse and related harm was published in 2004 and was the first attempt of the UK government to tackle alcohol problems in a co-ordinated manner. The strategy was revised in 2007 and the review *Safe, Sensible, Social* set a long term goal to minimise the harm to health, violence and anti-social behaviour associated with alcohol, while ensuring people are still free to enjoy alcohol safely and responsibly.[64] *Time to Call Time*, reflects these national objectives with its aims including reducing the health and harm caused by alcohol and reducing the economic and social harms, whilst keeping the economic and social benefits.[59]

The North West Mental Wellbeing survey provides a detailed overview of the alcohol consumption of adults aged 16 to 64 years.[16] **Across Cumbria, 62.0% of adults were drinking within sensible limits, while 10.0% of individuals were classified as hazardous drinkers and a further 2.2% were consuming alcohol at harmful levels.** There were few significant differences across Cumbria between local authority areas. **Eden had by far the highest proportion of adults who were sensible drinkers (79.1%, significantly higher than in all other areas). Whereas adults living in Barrow-in-Furness were significantly more likely to drink hazardously (17.0%) compared with the local authority areas of Allerdale, Carlisle, Eden and South Lakeland.**

As is consistent with national trends, people from the more disadvantaged areas of Cumbria were most likely to drink alcohol at levels that increase risks to health. **Significantly fewer people within the most deprived (51.5%) and second most deprived (49.7%) areas were sensible drinkers compared with other areas** (Figure 7). **Adults living within the two most deprived fifths of areas were also significantly more likely to be hazardous drinkers (15.7% in the second most deprived and 13.7% in the most deprived) than in the fourth and third most deprived areas (5.9% and 8.9% respectively).**

Figure 7: Weekly alcohol consumption by Index of Multiple Deprivation 2007. Cumbria, 2009.



Source: NWPHO from Cumbria Mental Wellbeing Survey 2009 and Communities and Local Government (Index of Multiple Deprivation 2007).

In Cumbria, **adults with below average mental wellbeing were the most likely to drink monthly or less (39.5%) compared with people who had average or above average mental wellbeing (17.4% and 17.7% respectively)** (Table 6). Adults with above average mental wellbeing were significantly more likely to drink daily or almost daily compared to other groups.

Table 6: Frequency of drinking alcohol by level of mental wellbeing. Cumbria, 2009.

Mental wellbeing	Never (%)	Monthly or less (%)	Once or twice a week (%)	Three or four days a week (%)	Daily or almost daily (%)	Don't know/ Refused (%)
Below average	23.9	39.5	26.2	5.2	5.0	0.2
Average	26.1	17.4	38.0	11.6	6.8	0.1
Above average	27.8	17.7	33.8	6.8	13.5	0.4

Source: NWPHO from Cumbria Mental Wellbeing Survey 2009.

Promoting healthier lifestyle choices - alcohol

Reducing the harm from alcohol is another contemporary public health issue that is a challenge because drinking alcohol is a part of our culture and the vast majority of people enjoy having a drink with friends and family. However, Cumbria, as with the rest of England, has too many people who are drinking too much alcohol too often. The number of people who are drinking at harmful levels need to be reduced and the wider effects that this behaviour has across the county need to be addressed. Cumbria's alcohol strategy, *Time to Call Time*, set out the ways in which this can be achieved; however there is still a lot more to be done to reduce the harm from alcohol in the county.[65]

Time to Call Time strategy objectives

- To reduce the harm to health caused by alcohol;
- To reduce alcohol related crime and anti-social behaviour;
- To safeguard children and young people; and,
- To reduce the economic and social harms, whilst keeping the economic and social benefits.

Cumbria's Alcohol Strategy 2008-2011, Cumbria Drug and Alcohol Action Team, 2008

There are no quick or simple solutions to the various types of harm that alcohol can cause. A range of policies need to be adopted at both the population and individual level that will change attitudes and behaviour in relation to alcohol in order to make further progress. Policies at the population level include the price and availability of alcohol for purchase while for individuals it is about brief interventions with health professionals and access to services for alcohol. This whole process must include all those involved with alcohol – people who drink, licensed premises, high street retailers, public services that deal with the consequences of alcohol on a daily basis and so on – so that we can reduce the harm that alcohol is causing across the county. Early interventions to change people's behaviour are more likely to be effective than when a pattern of drinking has already become established.

While some policies can only be determined at a national level, such as a minimum price or the level of tax on alcohol, there are many steps that we can take locally that can reduce the harm from alcohol. These efforts need to be concentrated on particular issues in specific localities to have the maximum effect. For example, reducing the level of hospital admissions in Allerdale, Barrow-in-Furness, Carlisle and Copeland must be a priority given that they are significantly worse than the rest of England. There are decisions that can be made locally about licensed premises that can reduce the harm that can flow from alcohol. For example, Cumbria's alcohol and drugs advisory service (CADAS) provides training for community ambassadors who serve as a bridge between communities and alcohol service providers helping in the development of co-produced services. Interventions need to be imaginative and inclusive to reduce the harm that can be caused by alcohol, while remaining mindful of the impact on health inequalities so that the social gradient can be reduced through these actions.

Conclusions and recommendations

In many ways, the proportion of adults who are *living well* in Cumbria is similar to the rest of England in terms of the health and social indicators of adult life. Life expectancy for men and women is similar to England as are the proportions of people in paid employment and claiming incapacity-related benefits. The proportions of people who are obese, physically active, eating healthily, smoking and drinking alcohol are also broadly similar to the national levels. Although Cumbria appears to be 'average' compared to the rest of England, there are considerable variations and inequalities within the county that have been highlighted throughout this and other reports in this series.

We are certainly wealthier than we were a generation ago but whether we are happier is questionable. The North West Mental Wellbeing Survey is an important source of baseline data that can be used in the future to assess progress in improving the quality of life of people across the county.

To maintain improvements in public health, the wider social determinants of health such as the world of work and the housing market need to be addressed. Creating sustainable jobs that offer opportunities for people across the county to enjoy the benefits that purposeful paid work can bring is essential, especially given the economic difficulties experienced in recent times. Cumbria has a commendable heritage from the industrial era and must be at the forefront of the next wave of environment sustaining job creation as well as maintaining the traditional areas of employment such as tourism, the energy sector and remaining heavy industry and agricultural jobs. Cumbria needs to be an economically attractive county, as well as being a beautiful environment, if it is to provide opportunities for young people to stay in the county and for people of working age to stay and move to the county in search of a better quality of life. Effective and sustainable employment

opportunities and support programmes to assist people to move from welfare to work must be developed, particularly in communities that are blighted by ill health and disability.

Given that the population of the county is forecast to increase by around 60,000 people in the next couple of decades, the housing situation needs to be addressed. This demographic trend coupled with the social trend of more people living alone means there is a continued need to address housing policy at a strategic and local level. More affordable homes will be required, and the quality of the housing stock must be improved for people living now and the older population in the future.

The role of the public health service is increasingly going to involve helping people to lead a healthier lifestyle characterised by good mental health and wellbeing, maintaining a healthy weight, eating healthily, being physically active and not smoking or drinking alcohol at harmful levels. Fully engaging people with managing a healthy lifestyle so that they can maintain good health, or more effectively self care if people have a long-term condition, is going to be an increasingly important part of public health. This must be achieved in many ways in communities and neighbourhoods across Cumbria because it is not possible to rely on the old methods of simply telling people that smoking or drinking too much is bad for their health.

We need to develop the assets that are already based in communities across the county and not just because of the cuts in the public sector but because co-producing services is the best way to nurture solutions to the public health challenges we face. If 'we are all in this together' in building the big society – and let us celebrate the fact that Eden is one of four trailblazers for this initiative – then the managers of public sector organisations and the professionals on the frontline need to work in genuine partnership with the public. We have great resilience and community spirit across the county and the abilities, civic pride and generosity of the people of Cumbria are our greatest assets.

Recommendations for action to help people to *live well* in Cumbria:

- Improving the health and wellbeing of all adults across Cumbria is the primary aim so that all people in the county have a better chance of *living well* now and in the future. Addressing the wider social determinants of health such as the labour market and housing is essential to this aim.
- Improve access to good quality jobs that promote health and reduce long-term unemployment and inactivity that damages it. People who are long-term sick or disabled need to be supported back into work through local initiatives and employers must be encouraged to create jobs that are flexible and sustainable in economic, social and environmental terms.
- Address the affordability of private housing, the availability of social housing and the quality of all homes. A survey of housing conditions in the private sector needs to be conducted in order to assess the quality of the housing stock and plans can be developed and put into operation for lifetime homes that will meet the needs of Cumbria's ageing population.
- Improve the mental health and wellbeing of Cumbrian people at both an individual and population level. Encouraging people to connect, be active, take notice, keep learning and to give, needs to be matched by organisations and professionals addressing mental health and wellbeing in the

workplace, building resilient communities by promoting social networks and taking a holistic view of physical and mental health.

- Long-term conditions need to be prevented or delayed but tens of thousands of people across the county will develop conditions such as hypertension and diabetes. Self care must be promoted through the provision of programmes, such as DESMOND for type 2 diabetes, that enable people to more effectively manage their health, improve their quality of life and reduce demand for health care services. Health checks for adults between the ages of 40 and 74 years that identify the risk of cardiovascular diseases need to be implemented with an emphasis on hard to reach groups such as men in disadvantaged areas of the county who are often reluctant to go to their GP.
- Obesity, healthy eating and physical activity form a triangle of lifestyle behaviours that are inter-connected and there is a need to develop ways of persuading people to eat well and move more in order to live longer. The Your Health Counts initiative provides practical advice and guidance on leading a healthier lifestyle and Active Cumbria is getting more people to be physically active but there is a lot more to be done. Developing solutions to these issues through co-production and developing the assets that are based in communities around the county, such as small scale incentive schemes for weight loss and healthy living or green gyms, is essential if people are to make and sustain lifestyle changes.
- NHS stop smoking services have helped thousands of people to give up smoking and should continue to be developed. Small scale interventions such as 'Quit and Win' that provided free access to leisure centres need to be evaluated to assess their effectiveness. Brief interventions by health care professionals with people who smoke and local campaigns to change behaviour both continue to be needed.
- Reducing the harms to individual health and communities that can be caused by alcohol is essential as Cumbria has some of the worst indicators of public health in England. While some decisions, such as the taxation of alcohol, can only be made at a national level, there are many actions that can be taken locally. Decisions about licensed premises, a range of brief interventions by health care professionals and building bridges between local communities and alcohol service providers are all essential.

References

1. Marmot Review (2010). Fair Society, Healthy Lives: Strategic Review of Health Inequalities in England post-2010 [Online]. Available at: *www.marmotreview.org/* [Accessed 11-10-2010].
2. National Equality Panel (2010). An anatomy of economic inequality in the UK: Report of the National Equality Panel [Online]. Government Equalities Office/Centre for the Analysis of Social Exclusion. Available at: *www.equalities.gov.uk/pdf/NEP%20Report%20 bookmarkedfinal.pdf* [Accessed 27-1-2010].
3. Cabinet Office (2010). State of the nation report: poverty, worklessness and welfare dependency in the UK [Online]. Available at: *www.cabinetoffice.gov.uk/publications/state-of-nation-report.aspx* [Accessed 28-5-2010].
4. Office for National Statistics (2010). Labour market statistics [Online]. Available at: *www.statistics.gov.uk/pdfdir/lmsuk0910.pdf* [Accessed on 16-9-2010].
5. Gregg P (2010). Osborne's haste will undermine incapacity benefit reform [Online]. Available at: *www.guardian.co.uk/commentisfree/2010/jul/06/ osborne-haste-undermine-incapacity-benefit-reform* [Accessed 6-7-2010].
6. Taske N, Taylor L, Mulivhill C, Doyle N, Goodrich J and Killoran A (2005). Housing and public health: a review of reviews of interventions for improving health: evidence briefing [Online]. Available at: *www.nice.org.uk/niceMedia/pdf/housing_ MAIN%20FINAL.pdf* [Accessed 11-10-2010].
7. Battersby S. Housing (2009). Health and Inequalities - the Environmental Health Perspective [Online]. Available at: *www.cieh.org/uploadedFiles/Core/Membership/ Regional_network/North_west_region/Housing_ Health_Inequalities.pdf* [Accessed 11-10-2010].
8. World Health Organization (2007). Local Housing and Health Action Plans: a manual [Online]. Available at: *www.euro.who.int/__data/assets/pdf_ file/0004/98698/E91004.pdf* [Accessed 11-10-2010].
9. Reynolds L, Parson H, Baxendale A and Dennison A (2008). Breaking point: How unaffordable housing is pushing us to the limit [Online]. Available at: *http://england.shelter.org.uk/__data/assets/ pdf_file/0009/86787/Breaking_Point.pdf* [Accessed 11-10-2010].
10. Rice T (2006). Against the odds: An investigation comparing the lives of children on either side of Britain's housing divide [Online]. Available at: *http://england.shelter.org.uk/__data/assets/pdf_ file/0004/173398/AgainstTheOdds_full_report.pdf* [Accessed 11-10-2010].
11. Cumbria Sub Regional Housing Group (2006). Cumbria Housing Strategy 2006/2011 [Online]. Available at: *www.impacthousing.org.uk/Adobe%20docs/ CSRHG%20Strategy/Housing%20Market%20 Main%20FINAL.pdf* [Accessed 11-10-2010].
12. Communities and Local Government (2008). Lifetime Homes, Lifetime Neighbourhoods: A National Strategy for Housing in an Ageing Society [Online]. Available at: *www.communities.gov.uk/documents/housing/pdf/ lifetimehomes.pdf* [Accessed 11-10-2010].
13. Joseph Rowntree Foundation (2009). Housing and Neighbourhoods Monitor [Online]. Available at: *www.hnm.org.uk/charts/housing-supply.html#one* [Accessed 11/10/2010].
14. Communities and Local Government (2010). English Housing Survey Headline Report 2008-09 [Online]. Available at: *www.communities.gov.uk/documents/statistics/ pdf/1479789.pdf* [Accessed 11/10/2010].
15. The Government Office for Science (2008). Foresight Mental Capital and Wellbeing Project. Final Project Report – Executive Summary [Online]. Available at: *www.bis.gov.uk/assets/biscore/corporate/ migratedD/ec_group/116-08-FO_b* [Accessed 21-9-2010].
16. Deacon L, Carlin H, Spalding J, Giles S, Stansfield J, Hughes S, Perkins C and Bellis MA (2009). North West Mental Wellbeing Survey 2009 [Online]. Available at: *www.nwph.net/nwpho/ NorthWestMentalWellbeingSurvey.pdf* [Accessed 21-9-2010].
17. Department of Health (2010). Confident Communities, Brighter Futures: A framework for developing wellbeing [Online]. Available at: *www.nmhdu.org.uk/silo/files/confident-communities-brighter-futures.pdf* [Accessed 21-9-2010].
18. The Guardian (2009). In praise of Cumbrian spirit [Online]. Available at: *www.guardian.co.uk/commentisfree/2009/dec/10/ in-praise-cumbria-flooding-community* [Accessed 21-9-2010].

19. NHS Information Centre for Health and Social Care (2010). Prescriptions Dispensed in the Community: England, Statistics for 1999 to 2009 [Online]. Available at: *www.ic.nhs.uk/statistics-and-data-collections/primary-care/prescriptions/prescriptions-dispensed-in-the-community-england--statistics-for-1999-to-2009* [Accessed 4-10-2010].

20. Goodwin N, Curry N, Naylor C, Ross, S and Duldig W (2010). Managing people with long-term conditions [Online]. Available at: *www.kingsfund.org.uk/current_projects/gp_inquiry/dimensions_of_care/the_management_of_1.html* [Accessed 4-10-2010].

21. Primary Care Commissioning (2007). Primary Care Service Framework: Management of Long Term Conditions in Primary Care [Online]. Available at: *www.pcc.nhs.uk/uploads/medical/pcsf/primary_care_service_framework__ltc_v7_final.pdf* [Accessed 4-10-2010].

22. National Primacy Care Research and Development Centre (2010). Self management [Online]. Available at: *www.npcrdc.ac.uk/ProjectResults.cfm?Theme=1* [Accessed 4-10-2010].

23. Phillips J (2010). Self care reduces costs and improves health – the evidence [Online]. Available at: *www.expertpatients.co.uk/sites/default/files/publications/EVIDENCE%20FOR%20THE%20HEALTH.pdf* [Accessed 4-10-2010].

24. British Medical Association Health Policy and Economic Research Unit (2006). Improving the management of long-term conditions in the face of system reform [Online]. Available at: *www.bma.org.uk/images/longtermconditions_tcm28-20870.pdf* [Accessed 4-10-2010].

25. Department of Health (2010). Improving the health and wellbeing of people with long term conditions [Online]. Available at: *www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_111187.pdf* [Accessed 4-10-2010].

26. NHS Choices (2010). High blood pressure [Online]. Available at: *www.nhs.uk/conditions/Blood-pressure-(high)/Pages/Introduction.aspx* [Accessed 4-10-2010].

27. Department of Health (2009). The Coronary Heart Disease National Service Framework Building on excellence, maintaining progress. Progress report for 2008 [Online]. Available at: *www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_096555* [Accessed 4-10-2010].

28. Hunter D (2010). What makes people healthy and what makes them ill? in Campbell F (ed) The social determinants of health and the role of local government [Online]. Available at: www.idea.gov.uk/idk/aio/17778155 [Accessed 4-10-2010].

29. Ashton J (2010). Inequalities, assets and local government – opportunities for democratic renewal posed by the global economic crisis. in Campbell F (ed) The social determinants of health and the role of local government [Online]. Available at: *www.idea.gov.uk/idk/aio/17778155* [Accessed 4-10-2010].

30. National Institute for Health and Clinical Excellence (2010). Prevention of cardiovascular disease at population level. NICE public health guidance 25 [Online]. Available at: *www.nice.org.uk/nicemedia/live/13024/49273/49273.pdf* [Accessed 21-9-2010].

31. Diabetes UK (2008). Diabetes: The Silent Assassin [Online]. Available at: *www.diabetes.org.uk/Get_involved/Raising-awareness/Silent-Assassin-campaign/* [Accessed 29-9-2010].

32. Craig R and Mindell J (eds) (2008). Health Survey for England 2006. Volume 1: Cardiovascular disease and risk factors in adults [Online]. Available at: *www.ic.nhs.uk/webfiles/publications/HSE06/HSE%2006%20report%20VOL%201%20v2.pdf* [Accessed 28-9-2010].

33. Gillett M, Dallosso H, Dixon S, Brennan A, Carey M, Campbell M, Heller S, Khunti K, Skinner T and Davies M (2010). Delivering the diabetes education and self management for ongoing and newly diagnosed (DESMOND) programme for people with newly diagnosed Type 2 diabetes: cost effectiveness analysis. *British Medical Journal,* 341:c4093.

34. Hunter D, Popay J, Tannahill C and Whitehead M (2010). Getting to grips with health inequalities at last? Editorial comment, *British Medical Journal,* 340:c684.

35. NHS Information Centre (2010). Statistics on obesity, physical activity and diet: England, 2010 [Online] Available at: *www.ic.nhs.uk/webfiles/publications/opad10/Statistics_on_Obesity_Physical_Activity_and_Diet_England_2010.pdf* [Accessed 17-9-2010].

36. Butland B, Jebb S, Kopelman P, McPherson K, Thomas S, Mardell J and Parry V (2007). Foresight. Tackling Obesities: Future Choices – Project report [Online]. Available at: *www.bis.gov.uk/assets/bispartners/foresight/docs/obesity/17.pdf* [Accessed 17-9-2010].

37. Brown M, Byatt T, Marsh T and McPherson K (2010). A prediction of obesity trends for adults and their associated diseases: Analysis from the Health Survey for England 1993-2007 [Online]. Available at: *http://nhfshare.heartforum.org.uk/RMAssets/NHFreports/NHF_adultobese_short_170210.pdf* [Accessed 17-9-2010].

38. Chief Medical Officer (2010). 2009 Annual Report of the Chief Medical Officer [Online]. Available at: *www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_114012.pdf* [Accessed 21-9-2010].

39. Craig R, Mindell J and Hirani V (2009). Health Survey for England: Physical activity and fitness. Summary of key findings [Online]. Available at: *www.ic.nhs.uk/webfiles/publications/HSE/HSE08/HSE_08_Summary_of_key_findings.pdf* [Accessed on 28-9-2010].

40. Healthcare Commission (2008). The State of Healthcare [Online]. Available at: http://webarchive.nationalarchives.gov.uk/20100611090857/http://*www.cqc.org.uk/_db/_documents/State_of_Healthcare_2008.pdf* [Accessed 27-9-2010].

41. Department of Health (2010). A Smoke free Future [Online]. Available at: www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_111789.pdf [Accessed 27-9-2010].

42. Dr Foster Intelligence (2008). Treating Inequalities. Intelligence issue 3 [Online]. Available at: *www.drfosterintelligence.co.uk/newsPublications/localDocuments/Intelligence3_19.06.08.pdf* [Accessed 27-9-2010].

43. National Institute for Health and Clinical Excellence (2008). Identifying and supporting people most at risk of dying prematurely [Online]. Available at: *www.nice.org.uk/nicemedia/live/12068/42086/42086.pdf* [Accessed 27-9-2010].

44. NHS Information Centre for Health and Social Care (2010). Statistics on Smoking: England, 2010 [Online]. Available at: *www.ic.nhs.uk/webfiles/publications/Health%20and%20Lifestyles/Statistics_on_Smoking_2010.pdf* [Accessed 27-9-2010].

45. National Institute for Health and Clinical Excellence (2006). Brief interventions and referral for smoking cessation in primary care and other settings [Online]. Available at: *www.nice.org.uk/nicemedia/live/11375/31864/31864.pdf* [Accessed 29-9-2010].

46. National Institute for Health and Clinical Excellence (2008). Smoking cessation services in primary care, pharmacies, local authorities and workplaces, particularly for manual working groups, pregnant women and hard to reach communities [Online]. Available at: *www.nice.org.uk/nicemedia/pdf/PH010guidance.pdf* [Accessed 28-9-2010].

47. Health England (2009). Prioritising investments in preventative health [Online]. Available at: *http://help.matrixknowledge.com/* [Accessed 28-9-2010].

48. Action on Smoking (2008). Beyond Smoking Kills: Protecting children, reducing inequalities [Online]. Available at: *www.ash.org.uk/current-policy-issues/beyond-smoking-kills* [Accessed 28-9-2010].

49. Cahill K, Perera R (2009). Competitions and incentives for smoking cessation. Cochrane Database of Systematic Reviews 2008, Issue 3 [Online]. Available at: *www.thecochranelibrary.com/SpringboardWebApp/userfiles/ccoch/file/World%20No%20Tobacco%20Day/CD004307.pdf* [Accessed 29-9-2010].

50. World Health Organization (2010). Alcohol [Online]. Available at: *www.who.int/substance_abuse/facts/alcohol/en/index.html* [Accessed 27-9-2010].

51. Faculty of Public Health Medicine (2008). Alcohol and Public Health [Online]. Available at: *www.fphm.org.uk/resources/AtoZ/ps_alcohol.pdf* [Accessed 27-9-2010].

52. NHS Information Centre for Health and Social Care (2010). Statistics on Alcohol, England 2010 [Online]. Available at: *www.ic.nhs.uk/webfiles/publications/alcohol10/Statistics_on_Alcohol_England_2010.pdf* [Accessed 27-9-2010].

53. Cabinet Office Strategy Unit (2004). Alcohol Harm Reduction Strategy for England 2004 [Online]. Available at: *http://webarchive.nationalarchives.gov.uk/20100416132449/http://www.cabinetoffice.gov.uk/media/cabinetoffice/strategy/assets/caboffce%20alcoholhar.pdf* [Accessed 27-9-2010].

54. Boyce T, Robertson R and Dixon A (2008). Commissioning and Behaviour Change: Kicking Bad Habits Final Report [Online]. Available at: *www.kingsfund.org.uk/publications/kbh_final_report.html* [Accessed 27-9-2010].

55. NHS North West and Department of Health (2010). Our Life in the North West: Tackling health inequalities locally a self assessment framework [Online]. Available at: *www.nwph.net/champs/Lists/Weekly%20Bulliten/Attachments/180/HI%20%20self-assessment%20framework.pdf* [Accessed 27-9-2010].

56. Department of Health (2008). Health Inequalities, Progress and next steps [Online]. Available at: *www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_085312.pdf* [Accessed 27-9-2010].

57. North West Public health Observatory (2010). Local Alcohol Profiles for England [Online]. Available at: *www.nwph.net/alcohol/lape/index.htm* [Accessed 27-9-2010].

58. Healthcare Commission & Audit Commission (2008). Are we choosing health? The impact of policy on the delivery of health improvement programmes and services [Online]. Available at: *www.audit-commission.gov.uk/SiteCollectionDocuments/AuditCommissionReports/NationalStudies/AreWeChoosingHealth_tagged16Jul08REP.pdf* [Accessed 27-9-2010].

59. Cumbria Drug and Alcohol Action Team (2008). Time to Call Time. Cumbria Alcohol Strategy 2008-11 [Online]. Available at: *www.cumbria.gov.uk/elibrary/Content/Internet/543/3956083952.pdf* [Accessed 27-9-2010].

60. Home Office Statistical Bulletin (2010). Crime In England and Wales 2009/10. Findings from the British Crime Survey and police recorded crime second edition [Online]. Available at: *http://rds.homeoffice.gov.uk/rds/pdfs10/hosb1210.pdf* [Accessed 27-9-2010].

61. Hughes K, Anderson Z, Bellis MA, Morleo M, Jarman I and Lisboa P (2009). Blood alcohol levels and drunkenness among people visiting nightlife in the North West [Online]. Available at: *www.cph.org.uk/showPublication.aspx?pubid=617* [Accessed 27-9-2010].

62. Association of Public Health Observatories (2010). Health Profiles 2010 [Online]. Available at: *www.apho.org.uk/resource/view.aspx?RID=50215®ION=50151* [Accessed 27-9-2010].

63. Coleman K, Jansson K, Kaiza P and Reed E (2007). Homicides, Firearm Offences and Intimate violence 2005/6: Supplementary Volume 1 to Crime in England and Wales 2005-6 [Online]. Available at: *http://rds.homeoffice.gov.uk/rds/pdfs07/hosb0207.pdf* [Accessed 27-9-2010].

64. Department of Health (2007). Safe, Sensible, Social. The next steps in national alcohol strategy [Online]. Available at: *www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_075219.pdf* [Accessed 27-9-2010].

65. National Institute for Health and Clinical Excellence (2010). Alcohol-use disorders: preventing the development of hazardous and harmful drinking. Public Health guidance 24 [Online]. Available at: *www.nice.org.uk/nicemedia/live/13001/48984/48984.pdf* [Accessed 1-10-2010].

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