# Healthy Living and Lifestyles Chapter – Cumbria JSNA, 2015 onwards

# October 2015

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# 1 Key issues & gaps

### Alcohol misuse

Based on the Acorn type profile of Cumbria's residents, the county has slightly greater estimated proportions of women who consume more than 3 units of alcohol per day (Cumbria 30.1% vs. UK 28.8%) and men who consume more than 4 units of alcohol per day (Cumbria 42.4% vs. UK 41.4%).

The directly standardised rate per 100,000 population for alcohol related hospital admissions in people aged 18+ in Cumbria between 2008/09 and 2012/113 is consistently significantly higher than England.

The rates for Allerdale, Barrow-In-Furness and Copeland have been consistently above the national average during this time. In Allerdale the rate of alcohol specific mortality in females of 12.9 per 100,000 was significantly worse than England at 7.5 per 100,000.

### Substance misuse

Throughout 2014-15 there were 3,118 service users in contact with Unity (the provider of statutory drug and alcohol services in the county). Most service users (57.7%) use the service for drugs related issues; 42.3% use the service for alcohol related issues. Heroin is the main drug of services users across all districts

6000 people have registered for needle exchange with the majority of users reporting performance enhancers as their main drug

Drug crime has fallen marginally across the county. Throughout 2013-14 there were 1,529 drug offences in Cumbria, 0.1% decrease from the previous year.

### Smoking

In 2011/13 an estimated 296.5 deaths in Cumbria were attributable to smoking per 100,000 population (aged 35+); this was similar to the national average of 288.7 per 100,000 population. However, the county average masks variation between districts; with Allerdale, Barrow-in-Furness, Carlisle and Copeland all having significantly worse rates than the national average, while Eden and South Lakeland's rates were better than the national average.

There were 2,063 smoking attributable hospital admissions in people aged 35 and over per 100,000 population in 2011/13; this was significantly worse than the national rate of 1,645 per 100,000 population. Furthermore, all of Cumbria's districts except Eden had worse rates than the national average.

Smoking prevalence in Cumbria at 18.1% is similar to national figures

13.8% of pregnant women in Cumbria smoking at the time of delivery; this is significantly worse than the national average of 12%.

There is little understanding of e-cigarette use in Cumbria

### Healthy Weight and Healthy Eating

The Active People Survey in 2012 recorded adult excess weight and in Cumbria 68.3% of the population is estimated to be overweight and this is significantly higher than England which is 63.8%. In the survey Copeland district reported the highest proportion of adults

overweight in the country at 75.9%. The districts Carlisle and Eden also have a proportion overweight greater than England, 68.4% and 68.8%.

The obesity prevalence in adults (BMI over 30) ranges from 1.41% and 18.58% in Cumbria CCG practices compared to 9.84% across England.

**Physical Activity**

Although the percentage of adults (16+) who report undertaking 150 minutes of moderate intensity physical activity for Cumbria is higher at 56.3% than the national average (55.6%), some of the districts e.g. Barrow-in-Furness (52.3%) and Carlisle (50.4%) are significantly below the national average

The percentage of adults who are inactive is higher in Barrow-in-Furness (36.1%) and Carlisle (35.1%), in comparison the figure for Cumbria (31.1%).

There is currently no up to date robust data available at a local level which details physical activity participation levels in children and young people.

**Sexual Health**

STI testing rates have been well below the national average between 2012 – 2014. Testing rates are increasing in all districts despite this they remain below England levels.

Recent increases in rates of both syphilis and gonorrhoea is predominantly in homosexual men aged 25-34 years, similar to the national picture.

Public Health England recommends that local authorities should be working towards achieving a chlamydia detection rate of at least 2,300 per 100,000 population. Cumbria currently has a detection rate of 1,707 per 100,000 aged 15-24 years. All districts except Carlisle have a detection rate below 2,300 per 100,000.

51.5% of adults presenting with HIV do so at a late stage in Cumbria compared to 48.3% in England. HIV testing uptake is below national rates, with 68.2% uptake in Cumbria compared to 77.5% in England.

There are not currently free condoms available to patients via GP practices unless provided by the practice themselves.

# 2 Recommendations for consideration for commissioners

Although each lifestyle factor has been addressed in separate section the vulnerable groups often overlap and the behaviours are not to be viewed in isolation. It is recommended commissioners consider all aspects included in this summary when considering healthy living and lifestyle.

# 3 Healthy Living and Lifestyles Introduction

Our health and well-being is influenced by a wide range of social, economic and environmental factors. The role of lifestyle factors, such as physical activity, alcohol, diet and smoking are well known to play a significant role.

In October 2014, NHS England published it's Five Year Forward View, which clearly highlighted the need to 'get serious about prevention' and made reference to the links between lifestyle and conditions such as diabetes.

Nationally, one third of adults are estimated to consume alcohol regularly at levels above the recommended limits. 33% of men and 50% of women are unlikely to get enough physical activity and around 66% of adults are overweight and obese. In addition, people living in deprived areas are less likely to be able to achieve or maintain a healthy lifestyle, showing a correlation between health inequalities and lifestyle.

People who find it difficult to have a healthy lifestyle are more likely to develop long term conditions that place pressure on health and social care services. Diabetes UK estimate that the NHS is already spending approximately £10 billion per year on diabetes. Almost three million people in England are living with diabetes and another seven million people are at risk of becoming diabetic, due to lifestyle factors.

England has made significant strides in reducing smoking, but it still remains our number one killer. More than half of the inequality in life expectancy between social classes is now linked to higher smoking rates amongst poorer people. There are now over 3,000 alcohol-related admissions to A&E every day.

By encouraging health lifestyles, we can help to prevent ill-health. Both stopping people get ill in the first place, or intervening early when they do to stop their conditions from worsening and helping people to manage their conditions through lifestyle management.

Financially, the coming years will be the most challenging in the history of the NHS and Social Care, with rising costs associated with long term conditions, our ageing population and the need to address behaviours such as smoking and obesity which lead to poorer health. This JSNA chapter on healthy living/lifestyles aims to support addressing the challenge by providing an assessment of need in the following areas:

- Alcohol misuse
- Substance misuse (not including alcohol)
- Smoking
- Healthy weight and Healthy Eating
- Physical Activity
- Sexual Health
- Mental Wellbeing

# 4 Alcohol misuse

## 4.1 What is the population overview?

Public Health England's Alcohol Learning Centre suggests 85% of adults drink alcohol and provides the following figures as an indication of alcohol harm for England (source: DH Health Improvement Analytics, Feb 2010):

- The DH lower-risk guidelines are
    - Men: should not regularly exceed 3-4 units/day
    - Women: should not regularly exceed 2-3 units/day

BUT - 21% (over 9 million) of adults in England drink more than the Government's lower-risk guidelines
AND - about 2 million adults drink at higher-risk levels

- 1.3 million men drink 50+ units/week
- 700,000 women drink more 35+ units/week.

The short-term effects of alcohol consumption can include:

- Severe headache, nausea, vomiting, diarrhoea and indigestion;
- Risk of alcohol poisoning (with symptoms including confusion, vomiting, seizures, slow breathing and unconsciousness and coma which could lead to death);
- Accidents and injury;
- Violence and antisocial behaviour;
- Unsafe sex (which can lead to unplanned pregnancies and sexually transmitted infections (STIs));
- Loss of personal possessions (such as wallet or mobile phone); and
- Unplanned time off work or college (which could put jobs or education at risk).

Long-term effects of alcohol misuse can include:

- Organ damage (including the brain and nervous system, heart, liver and pancreas);
- Increased blood pressure and blood cholesterol levels (both of which are major risk factors for heart attacks and strokes);
- Weakened immune system (increasing vulnerability to serious infections);
- Weakened bones (resulting in greater risk fractures and breaks);
- Conditions including high blood pressure, stroke, pancreatitis, liver disease, liver cancer, mouth cancer, head and neck cancer, breast cancer and bowel cancer;
- Depression;
- Dementia;
- Sexual problems and infertility;
- Family break-up and divorce;
- Domestic abuse;
- Unemployment;
- Homelessness; and
- Financial problems.

Alcohol consumption is a contributing factor to hospital admissions and deaths from a diverse range of conditions. Alcohol misuse is estimated to cost the NHS about £3.5 billion per year and society as a whole £21 billion annually.

- Alcohol is responsible for 8% of all hospital admissions
- 511,000 admissions in 2002/03
- 1.2 million individuals admitted in 2009/10
- Rising by 12% (111,000) between 2009/10 and 2010/11
- Alcohol misuse contributes to 48 conditions
    - 13 conditions are wholly attributable to alcohol consumption
    - 35 conditions are partially attributable to alcohol consumption
- Areas of highest deprivation (compared to more affluent areas) have:
    - 2 to 3 times higher loss of life
    - 2 to 5 times more admissions to hospitals

## 4.2 Who is at risk & why?

Local data and national evidence suggests that the following groups are more at risk of alcohol related harm:

**Age:**

- The 55-74 year-old age group

**Gender:**

- Men are more likely to drink more than the average recommended number of units per day and be admitted to hospital as a result of alcohol misuse
- Pregnant women are a particular group who could benefit from reduced alcohol consumption if they are drinking more than the recommended amounts

**Geographical and socio-economic factors:**

- Women living in rural areas of Cumbria are more likely to consume more than 3 units of alcohol per day. Residing in rural areas may make it more difficult to access support services.
- Men living in deprived urban areas are more likely to consume more than 4 units of alcohol per day
- High levels of alcohol consumption have been associated with problems with housing and unemployment, however Acorn profiling indicates that women and men in Cumbria are more likely to drink if they have professional careers

**Mental Health:**

- Alcohol dependence is almost twice as high among people diagnosed with a psychiatric condition, compared to the general population.
- A high proportion of people committing suicide in Cumbria had consumed alcohol prior to taking their own lives.

## 4.3 What is the level of need and gaps?

There are no data sources available for reporting local alcohol consumption and therefore other estimation tools have been utilised for assessing the level of need.

**Acorn Socio-Economic Profiling:**

Acorn is a socio-economic profiling tool which has been developed by the company CACI and is subscribed to by the Cumbria Intelligence Observatory, © 1979 – 2015 CACI Limited. This data shall be used solely for academic, personal and/ or non-commercial purposes. Acorn uses a range of information gathered from a number of administrative sources to classify each postcode in Great Britain as belonging to one of: 6 socio-economic categories; 18 socio-economic groups; and 62 socio-economic types.

Acorn uses national lifestyle survey information to estimate how likely people living in postcodes assigned to each socio-economic classification are to display various characteristics and behaviours, including a number of health behaviours. For example, Acorn estimates that across UK residents, 28.8% of women consume more than 3 units of alcohol per day and 41.4% of men consume more than 4 units of alcohol per day. However, Acorn also reports that levels of alcohol consumption vary considerably across socio-economic types so that, of the 62 Acorn types, the estimated proportions of women who consume more than 3 units of alcohol per day and men who consume more than 4 units of alcohol per day are greatest within Acorn Type 35 (Term-time terraces) postcodes (39.2% for women and 56% for men respectively). For a detailed description of any Acorn category, group or type, please see: http://acorn.caci.co.uk/downloads/Acorn-User-guide.pdf

Figure 1 presents the estimated proportions of women who consume more than 3 units of alcohol per day and men who consume more than 4 units of alcohol per day for the UK, Cumbria and districts based on the socio-economic profile of these geographies.

Figure 1: Estimated Proportion of Residents: Excess Alcohol Consumption: Based on Propensity of Acorn Socio-Economic Types in Area:

| | Alcohol Consumption: Women >3 units per day | Alcohol Consumption: Men >4 units per day |
|---|---|---|
| UK | 28.8 | 41.4 |
| Cumbria | 30.1 | 42.4 |
| Allerdale | 30.1 | 42.4 |
| Barrow-in-Furness | 30.2 | 44.1 |
| Carlisle | 30.0 | 42.7 |
| Copeland | 29.9 | 42.8 |
| Eden | 30.9 | 41.3 |
| South Lakeland | 30.1 | 41.3 |



Based on the Acorn type profile of Cumbria's residents, the county has slightly greater estimated proportions of women who consume more than 3 units of alcohol per day (Cumbria 30.1% vs. UK 28.8%) and men who consume more than 4 units of alcohol per day (Cumbria 42.4% vs. UK 41.4%). Of Cumbria's districts, Eden has the greatest estimated proportion of women who consume more than 3 units of alcohol per day (30.9%), while Barrow-in-Furness has the greatest estimated proportion of men who consume more than 4 units of alcohol per day (44.1%).

At a ward level the variation in estimated proportions of residents consuming excess alcohol was more substantial. Figure 2 lists the five wards in Cumbria with the greatest estimated proportions of male and female residents consuming more than the recommended number of alcohol units based of the Acorn socio-economic profile of these wards.

Figure 2: Cumbria Top 5 Wards: Greatest Estimated Excess Alcohol Consumption: Based on Propensity of Acorn Socio-Economic Types in Ward:

| Alcohol Consumption: | District | Ward Name | % Residents: Displaying Behaviour |
|---|---|---|---|
| Women >3 units per day | Allerdale | Crummock | 34.5 |
| | South Lakeland | Whinfell | 34.4 |
| | Allerdale | Warnell | 34.2 |
| | Eden | Skelton | 34.2 |
| | Eden | Crosby Ravensworth | 34.1 |
| Men >4 units per day | Barrow-in-Furness | Central | 46.8 |
| | Barrow-in-Furness | Hindpool | 46.6 |
| | Barrow-in-Furness | Barrow Island | 46.6 |
| | Carlisle | Castle | 46.4 |
| | Carlisle | St Aidans | 46.3 |

**Economic cost of alcohol misuse in Cumbria**

The following data in figure 3 is replicated from the Alcohol Concern 'Alcohol Harm Map' for Cumbria.

Figure 3: Cost of alcohol misuse in Cumbria

| Theme/Title | Count/Prevalence for Cumbria | Predicted cost to Cumbria (where available) |
|---|---|---|
| **Adults in Cumbria drinking at a level which increases the risk of damaging their health** | | |
| Higher risk drinkers: Drink at very heavy levels which significantly increases the risk of damaging their health and may have already caused some harm to their health | 24,734 (6%) | £5.6m per year (estimated local healthcare costs) |
| Increasing risk drinkers: Drink above the recommended levels which increases the risk of damaging their health | 73,323 (20%) | £16.6m per year (estimated local healthcare costs) |
| **Alcohol-related hospital admissions and attendances in 2012/13 in Cumbria** | | |
| A&E (accident and emergency) attendances | 51,831 | £5.9m |
| Inpatient admissions | 11,737 | £19m |
| Outpatient attendances | 27,002 | £2.5m |
| **Alcohol-related inpatient admissions 2012/13** | | |
| Admissions wholly attributable to alcohol | 3,047 | £5.3m |
| Admissions partly attributable to alcohol | 8,690 | £13.6m |
| Male inpatient admissions | 7,844 | £12.7m |
| Female inpatient admissions | 3,893 | £6.2m |
| 16-24 year olds | 466 | £0.6m |
| 25-54 year olds | 3,618 | £5.4m |
| 55-74 year olds | 5,571 | £8.8m |
| 75+ year olds | 2,080 | £4m |
| **Alcohol-attributable conditions – inpatient admissions attributable to alcohol in Cumbria** | | |
| Hypertensive diseases | 14% | £7,147,000 |
| Malignant neoplasm of breast | 13% | £264,000 |
| Head and neck cancers | 45% | £897,000 |
| Gastro-intestinal cancers | 14% | £473,000 |
| Epilepsy and status epilepticus | 24% | £985,000 |

Source: Alcohol Concern (2014) Alcohol Harm Map – Cumbria [online]. Available from http://www.alcoholconcern.org.uk/training/alcohol-harm-map/

Overall, high risk and increasing risk drinkers cost the Cumbria economy approximately £22.2 million during 2012/13.

The data also indicates that:

- Hospital treatment cost over twice as much for men as for women (£12.7 versus £6.2 million)
- The treatment of the 55-74 year-old age group was the most costly
- Hypertensive diseases, such as coronary heart disease, resulted in the greatest cost (when looking at admissions attributable to alcohol) - £7.1 million

**Alcohol Related Hospital Admissions & Mortality**

Figure 4 below shows the directly standardised rate/100,000 population for alcohol related hospital admissions in people aged 18+ by district between 2008/09 and 2013/14.

- The rates for Barrow-In-Furness and Copeland have been consistently above the national average during this time
- All districts except Allerdale and Copeland saw an increase in admission rate between 2012/13 and 2013/14

Figure 4: Alcohol related admissions to hospital (narrow definition - persons) – directly standardised rate/100,000

| | 2008/09 | 2009/10 | 2010/11 | 2011/12 | 2012/13 | 2013/14 |
|---|---|---|---|---|---|---|
| Allerdale | 461 | 457 | 465 | 464 | 480 | 455 |
| Barrow-In-Furness | 534 | 572 | 601 | 618 | 641 | 655 |
| Carlisle | 428 | 472 | 463 | 479 | 460 | 518 |
| Copeland | 546 | 546 | 525 | 525 | 516 | 511 |
| Eden | 325 | 341 | 345 | 371 | 332 | 360 |
| South Lakeland | 389 | 372 | 365 | 403 | 403 | 432 |
| **Cumbria** | 445 | 458 | 458 | 475 | 471 | 488 |
| **National Average** | 421 | 440 | 448 | 445 | 439 | 444 |

Further data relevant to alcohol misuse is available via the Local Alcohol Profiles for England: http://www.lape.org.uk/

The alcohol specific mortality rate (2011-13) in Cumbria was 11.5 per 100,000 of the population which is similar to England (11.9 per 100,000). In Allerdale the rate of alcohol specific mortality in females of 12.9 per 100,000 was significantly worse than England at 7.5 per 100,000. In the same period the number of months of life lost due to alcohol in males and females in Cumbria was 14 and 6.4 respectively.

## 4.4 Current Services and Assets including projections

Current services and assets include:

- Health Checks (commissioned by Cumbria County Council and provided by Primary Care) – include screening for alcohol consumption
- Newly registered patients at GP practices receive a brief alcohol intervention where appropriate.
- Unity – Specialist Substance Misuse Services
- CADAS – provides a drug and alcohol service to individuals, families, communities and employers with training and information provision
- Healthy Living Pharmacy – pharmacists trained as healthy living champions can provide advice around healthy drinking
- County-wide alcohol strategy group

The following alcohol misuse related support may be an unmet need in Cumbria:

- Support via workplaces to women in professional jobs
- Specialist substance misuse support for people in full time employment if there is not provision outside working hours

## 4.5 Evidence of what works

The Department of Health has identified a number of High Impact Changes which are calculated to be the most effective actions for those local areas that have prioritised the reduction in alcohol-related harm. High Impact Changes have been extensively used across the NHS and local government to highlight practical measures that can be implemented at local level:

1. **Work in partnership** – Ensure the Health and Wellbeing Locality Forums, county-wide Public Health Alliance and alcohol strategy group use JSNA alcohol data to prioritise actions that support alcohol-related harm

2. **Develop activities to control the impact of alcohol misuse in the community** - Make use of all the existing laws, regulations and controls available to all the local partners to minimise alcohol related harm.

3. **Influence change through advocacy** - Find high-profile champions to provide leadership within partner organisations and a focus for action to reduce alcohol harm

4. **Improve the effectiveness and capacity of specialist treatment** - Providing evidenced based, effective treatment as well as increasing treatment opportunities for dependent drinkers

5. **Appoint an Alcohol Health Worker** - Since their report in 2001, The Royal College of Physicians have advocated the appointment of a dedicated Alcohol Health Worker or an Alcohol Liaison Nurse in each major acute hospital

6. **IBA - Provide more help to encourage people to drink less** - Identification and Brief Advice (IBA) is opportunistic case finding followed by the delivery of simple alcohol advice

7. **Amplify national social marketing priorities** - Partners are advised to commission local social marketing activity which builds on the evidence, strategic framework and tools emerging from the national alcohol social marketing programme, such as direct marketing materials, wall charts and fact sheets for GPs, and the Your Drinking & You booklet.

Source: PHE Alcohol Learning Resources (2012) High Impact Changes [website] Available from: http://www.alcohollearningcentre.org.uk/Topics/Browse/HIC/ Accessed 03/06/2015

It's also helpful to note that tackling alcohol misuse can save money at a local level:

- Screening and brief advice have been shown to save £58,000 per 1,000 people screened in doctors surgeries.
- Specialist alcohol treatment can deliver savings of nearly £1,138 per dependent drinker treated and reduce hospital admissions.

- For every £1 invested in specialist alcohol treatment services, £5 is saved on health, welfare and crime costs.
- Both NICE and the Department of Health have recommended a target of 15% for drinkers to have treatment locally. Fully implementing this guideline in England would save £9.3 million per year.

Source: Alcohol Learning Centre

**Other sources of evidence and good practice:**

NICE, 'Alcohol-use disorders: preventing the development of hazardous and harmful drinking' (2010) http://www.nice.org.uk/nicemedia/live/13001/48984/48984.pdf

The Alcohol Learning Centre [ http://www.alcohollearningcentre.org.uk/ ]

## 4.6 User views

There is not evidence of a cumbria wide survey or consultation available to provide user views around alcohol.

In 2013, NHS Cumbria and Cumbria County Council commissioned Our Life to run an Alcohol Inquiry as part of the Talking Drink: Taking Action series. They worked with 25 residents in the Ormsgill ward of Barrow-in-Furness to try and answer the question 'What do we need to do to make it easier for people to have a healthier relationship with alcohol?' The first Inquiry session was held in May 2013 and the sessions ran until the end of July 2013. Participants heard from a wide range of people to create local recommendations to take action on the issues that matter to them. The recommendations related to education, availability of alcohol and provision of services. The full report can be found here (link to be added).

# 5 Substance misuse (excluding alcohol)

## 5.1 What is the population overview?

Substance abuse or misuse is formally defined as the continued misuse of any mind-altering substance that severely affects a person's physical and mental health, social situation and responsibilities. (Source: Mental Health Foundation). Drug use and substance abuse provides a temporary feeling of well-being but ultimately it can cause long term damage to health.
Prescribed medicinal drugs such as tranquillisers and sleeping tablets can also cause health problems especially if used for long term, in that they can cause anxiety and sleeplessness. Recreational drugs, such as cannabis and ecstasy, have different effects depending on an individuals' physiology, their mood and the environment, and the amount they use. In some cases first time use can cause serious issues, for others repeated use eventually causes issues. Drug misuse can cause both physical and psychological symptoms.

Drug users often rely on drugs to help them feel less anxious or depressed or to improve their mood. Often they are used for circumstances such as loneliness, family or relationship issues, socio-economic reasons such as poverty or housing, unemployment and lack of opportunities.

Offending behaviour is closely linked to substance misuse and evidence shows that reoffending reduces significantly if drug use stops. Preventing and terminating a person's drug misuse will have benefits to a range of services and will address those who cause the most harm in local communities (source: PHOF).

The 2013/14 national crime survey for England and Wales shows:

- The prevalence of frequent drug use has remained broadly similar over the last three years. In 2013 to 2014, 3.1% of adults aged 16 to 59 were defined as frequent drug users (having taken any illicit drug more than once a month on average in the last year), a slightly higher proportion than in 2012 to 2013 (2.8%) but similar to the 2011 to 2012 proportion (3.2%).
- Young adults were more likely to be frequent drug users than older people. The proportion of young adults aged 16 to 24 classed as frequent drug users (6.6%) was more than twice as high as the proportion of all adults aged 16 to 59 (3.1%) in 2013/14 and represented a statistically significant increase compared with 2012/13 (5.1%).
- There were differences in levels of frequent drug use among respondents with different personal, household and area characteristics. Levels of use of any illicit drug more than once a month on average in the last year were higher among men than women, among those who went to pubs or nightclubs more often and among those who lived in more deprived areas.

In Cumbria the estimated population size of those injecting drugs is 2887 (source PHE using king et al methodology) this is an estimate based on crack and opiate users and the estimate does not included injectors of performance enhancing drugs or amphetamines. In Cumbria, of those registered at for needle exchange services over 60% report amphetamine and performance enhancing drugs as their main drug.

## 5.2 Who is at risk & why?

### Prescription Drugs

The drug scope survey in December 2014 across 17 towns and cities in the UK described an increase in prescription drug misuse, most areas covered by the survey highlighted the significant use of the prescription drugs pregabalin and gabapentin, chiefly among Britain's opiate-using and prison populations. Prescription drugs are now considered more widely available, through diversion of prescriptions and unregulated sales via the internet.
There is not any definitive data of numbers involved in prescription drug misuse or dependence on prescription and over-the-counter medicines, including dependence arising inadvertently from the prescribed use of a medicine.

### Benzodiazepene prescribing rates

In England deaths registered in 2013 involving benzodiazepines have shown a significant increase for males, from 284 in 2012 to 342 in 2013. (ONS, Sept 2014)

From October 2013 to September 2014 there were 168,025 hypnotic and anxiolytic items prescribed by Cumbria CCG. 40,495 in July to Sept 2014 compared to 44,310 July to Sept on 2013 with figures decreasing each quarter since April 2013.
Source: iview HSCIC data

### Lesbian, Gay, Bisexual and Transgender (LGBT) communities

Research indicates that, across all age groups, LGBT people are significantly more likely to use drugs and/or binge drink alcohol compared to the general population; they are also more likely to be dependent on these substances than the general population. Data from the British Crime Survey (2010/11) suggests that 'the use of any drug in the last month' is 7 times higher across all LGBT adults compared to the general population.

The range of recreational drugs used by LGBT communities is wide and includes the misuse of prescription drugs and steroids. Recreational drug use, particularly of methamphetamine, has been associated with risky sexual behaviour that may contribute to HIV transmission in gay and bisexual men.

Source: Buffin J, Roy A, Williams H et al. Part of the Picture: Lesbian, gay and bisexual people's alcohol and drug use in England (2009-2011). The Lesbian and Gay Foundation & University of central Lancashire 2012

### Offenders

There is considerable evidence that treatment interventions for the management of substance misuse can help to reduce offending.

Cumbria has a significantly lower than England (35.5% compared to 46.9%) number of people entering prison with substance misuse dependence issues that have not already been in contact with treatment. Source: PHOF
In the first six months of 2014/15 there were 577 new receptions at Haverigg and 23% began a treatment episode. Most (78%) of the new treatment entrants were opioid users. The majority (53%) of the 98 prisoners who were released in the first six months of 2014/15, were referred to CJIT and / or treatment provider.
Source: Prison quarterly treatment report NDTMS

For quarter 4, 2013/14 DIP referrals in treatment as a % of treatment population were 23% for opiate users and 16% for non opiate users
Source: PHE Cumbria area DIP report Q4 2013/14

Of 119 people taken onto caseload by CJIT, 53% are also in structured treatment.
Source: CJIT report June 2015

**Women**

Women and young girls can be vulnerable to alcohol and drug misuse in some circumstances for example, those subject to domestic violence or sexual assault, or involved in prostitution, or with poor mental health. The size of this risk group in Cumbria is unknown from data readily available and is a current gap.

**Homelessness**

The links between drug and alcohol abuse and homelessness are well established and drugs and alcohol are known to be both a cause and consequence of homelessness. For details of homelessness in Cumbria please refer to the Inequalities topic summary of the JSNA
http://www.cumbriaobservatory.org.uk/elibrary/Content/Internet/536/671/4674/6164/4219513456.pdf

## 5.3 What is the level of need and gaps?

**Substance misuse hospital admissions – poisoning by drugs**

In Cumbria there were 72 admissions in 2013/14 for primary diagnosis of drug related mental health or behaviour disorders which equates to a rate of 14 per 100,000 population compared to 13 per 100,000 in England. There were 628 admissions with a primary or secondary diagnosis equating to a rate of 126 per 100,000 population compared to a rate 127 per 100,000 in England.

NHS hospital admissions where a primary diagnosis of poisoning by illicit drugs was recorded equalled 161 in 2013/14 for Cumbria.

**Drug related deaths**

The National Programme on Substance Abuse Deaths report 2013 annual report suggests 23 drug related deaths of Cumbria residents in 2012, 21 occurring in Cumbria. Of those 21 a majority 12 were linked to hypnotics/sedatives, In England the highest % of deaths were attributed to heroin/morphine. The majority of those were male and aged 30-49 years.

**Prevalence estimates (latest 2011/12)**

Opiate and crack estimates are 2.4 per 1000 in Cumbria (95% confidence intervals, 2.2 to 2.7) and have remained consistently around this level since 2008/09. Treatment penetration is estimated for opiate and crack at 78.2 % (95% confidence intervals 70-85)

**Hepatitis C results and tool data**

There are estimated to be 2992 person infected with hepatitis C in Cumbria in 2013 (PHE tool).

**Needle exchange client data**

Since 2013 over 6000 people have registered for needle exchange with the majority of users reporting performance enhancers as the main drug. The majority of needle exchange users are aged between 30 and 40 years for heroin users and 20-30 years performance enhancer users. For amphetamine users the age of needle exchange users is less defined but majority are between 25 and 45 years. The majority registered are males for all drugs. Amphetamine is a common main drug in Allerdale, Carlisle and Copeland.

**Crime data**

From latest community safety strategic assessment (further detail can be found here http://www.cumbriaobservatory.org.uk/Crime/CSSA.asp):

Drug possession and supply has fallen marginally across the county but in particular in Carlisle (-13.5%), Copeland (-9.2%), Eden (-9.3%) and South Lakeland (-8.2%). Throughout 2013-14 there were 1,529 drug offences in Cumbria, 0.1% decrease from the previous year. Despite the overall fall, numbers of drug offences have increased in Allerdale (+26.1%) and in Barrow (+14.6%). Areas with the highest levels of drug crime are the wards of Castle in Carlisle and Central in Barrow. Offences tend to take place in urban areas and town centres however there remains a relatively high number of offences in the rural ward of Askham in Eden. The figures indicate that this continues to relate to the Kendal Calling music festival as numbers were at their highest in July when the festival takes place. The aim of Cumbria Constabulary is to increase the number of drug convictions and therefore reduce the number of drugs in circulation. In Cumbria drug possession was down by 3.3%; drug trafficking was up by 17.6%. Allerdale had the highest rate of offences per 1,000 population; South Lakeland had the lowest.

The wards with the highest number of crimes in each of the districts are:

**Allerdale:** St. John's, St. Michael's, Moss Bay

**Barrow**: Central, Hindpool, Risedale

**Carlisle**: Castle, Currock, Belle Vue

**Copeland**: Harbour, Sandwith, Bransty

**Eden**: Askham, Penrith West, Penrith South

**South Lakeland**: Windermere Bowness South, Kendal Fell, Kendal Strickland

The 'possession of drugs' crime rate in Cumbria is above the average and is ranked 3rd of its Most Similar Groups (out of 4 Forces). Drugs trafficking in Cumbria is above average and is the worst of its Most Similar Groups (4 out of 4).

In Cumbria, most offenders are male and aged between 18-30years. For all offences the pattern is similar however for female drug trafficking offenders the majority are slightly older in the 31-40 year category although there are notably fewer number compared to males.

Figure 5: Drug offences in Cumbria and Districts for the last 3 years

| | 2011/12 | 2012/13 | 2013/14 | % change in the last year | Rate (per 1,000) |
|---|---|---|---|---|---|
| **Cumbria** | 1,815 | 1,527 | 1,529 | -0.1 | 3.1 |
| **Allerdale** | 487 | 314 | 396 | +26.1 | 4.1 |
| **Barrow** | 187 | 206 | 236 | +14.6 | 3.5 |
| **Carlisle** | 477 | 466 | 403 | -13.5 | 3.7 |
| **Copeland** | 241 | 207 | 188 | -9.2 | 2.7 |
| **Eden** | 204 | 150 | 136 | -9.3 | 2.6 |
| **South Lakeland** | 219 | 184 | 169 | -8.2 | 1.6 |

**Drug and alcohol treatment**

This section looks at data in relation to drug and alcohol service users who come into contact with Unity (the county's provider of statutory drug and alcohol services).

Throughout 2014/15 there were 3,118 service users in contact with Unity (the provider of statutory drug and alcohol services in the county). Most service users (57.7%) use the service for drugs related issues; 42.3% use the service for alcohol related issues. Heroin is the main drug of services users across all districts, accounting for around 42% in the county as a total. 2 out of 3 service users are male and most are aged between 35-39 years (18.3%). 98% are white British. 1 in 5 service users have a child (or children) living with them; while 33.4% have children which live with either a partner or family member. The greatest proportion of drug service users are in the district of Carlisle (28.6%) and Barrow-in-Furness (24.2%).

Heroin users are more likely to be aged 30-40 years; those using performance enhancing drugs are more likely to be aged 20-30 years.

Opiates is the most presenting drug for prison referrals

## 5.4 Current Services and Assets including projections

There are many different substances and as such there are a wide variety of treatment options. In Cumbria a recovery focused integrated service which can respond to a range of substances including illicit drugs and alcohol is commissioned. Treatment and substitute medication are important elements of the recovery focus but there must be a clear timeline agreed so that individuals can eventually leave formal services and continue their recovery journey in their community.

Substance misuse is usually treated by specialist drug and alcohol services, in Cumbria these services are provided by Unity. Unity treatment locations are in Carlisle, Workington, Whitehaven, Barrow, Penrith and Kendal.

HMP Haverigg also has treatment provision.

Active recovery support organisations in Cumbria are in Carlisle (Cumbria Gateway, Jigsaws), Whitehaven (Vulture Club, BAT – Beating Addiction Together), Workington (New Beginnings), Barrow (New Roots)

## 5.5 Evidence of what works

Finding evidence to prove which interventions work can be difficult. For example, can success be judged by people in treatment completely giving up all drug use or by them moderating their use and being able to better function in their lives? How can the information be found out? Is it good enough to just ask people what they thought of treatment and whether it helped them? What measures of help should we use? Does it matter whether users stopped or moderated their drug use or whether their health improved? Would they have made changes in their drug use without the treatment?

Treatment is merely the means to the end. The end itself is recovery, being drug free.

However there is evidence that treatment helps people with drug problems. Much of the research is from America where medication assisted recovery was pioneered. This is most commonly recognised as the use of methadone to assist opiate addiction. Research has found that treatment helps people give up or moderate their drug use and can result in significant reductions in drug-related crime. It has also found that the quicker a person gets treatment the more likely it is they will stay in treatment and that it will be effective.

The National Institute for Health and Clinical Excellence (NICE) is the body which assesses the research evidence and provides guidance for NHS and other healthcare professionals, commissioners and providers. NICE is unequivocal in its recommendation of all the key aspects of drug treatment, including psychosocial interventions, needle and syringe programmes, and opioid maintenance and detoxification. The latest NICE guidelines can be found on their website, www.nice.org.uk.

The NICE assessment of the effectiveness and cost-effectiveness of methadone and buprenorphine maintenance therapy for treating opioid dependence is especially striking. *TA114 NICE Technology Appraisal Guidance for Methadone and Buprenorphine for the management of opioid dependence*, published in January 2007, considered evidence from 31 systematic reviews, as well as a further 27 randomised controlled trials. They found that methadone and buprenorphine treatment results in:

- more people retained in treatment
- lower rates of illicit opioid use
- fewer self-reported adverse events
- people being four times less likely to die
- decreased levels of criminal activity;
- and that the treatment was cost effective.

**Harm reduction**

Research consistently finds that needle exchanges (where dirty needles and other injecting equipment are exchanged for clean equipment), and other forms of support for injecting drug users (such as wound management), reduces needle sharing and the incidence of HIV and other blood borne viruses.

## 5.6 User views

There is not recent, cumbria wide evidence of user views for reference the big issue study in 2002 is available. The survey was carried out in Liverpool and Manchester by the Big Issue in 2002. They interviewed over 550 people who were using drug services. The main conclusions were:

- Most of the drug users were living in poverty and a quarter were homeless.
- A third had been in contact with drug services for more than 5 years.
- Over three quarters who were prescribed methadone were still using street drugs.
- Most of the users received mainly medical interventions but many said they also wanted counselling.
- Many were suspicious of GPs and wanted more community based drug services.

# 6 Smoking

## 6.1 What is the population overview?

Smoking is the primary cause of preventable illness and premature death, accounting for approximately 100,000 deaths a year in the United Kingdom. Smoking harms nearly every organ of the body and dramatically reduces both quality of life and life expectancy. Smoking causes lung cancer, respiratory disease and heart disease, as well as numerous cancers in other organs including lip, mouth, throat, bladder, kidney, stomach, liver and cervix.

In England it is estimated that in 2012-13, among adults aged 35 and over, around 460,900 NHS hospital admissions were attributable to smoking, accounting for 5% of all hospital admissions in this age group. The cost of smoking to the National Health Service in England is estimated to be £2 billion a year.

In 2013, 17 per cent (79,700) of all deaths of adults aged 35 and over in England were estimated to be attributable to smoking (around one in six).

Of these smoking caused:

• 37,200 (28%) of all cancer deaths
• 24,300 (35%) of all respiratory deaths
• 17,300 (13%) of all circulatory disease deaths

*Source: ASH (2014) 'Smoking statistics – Illness and Death' factsheet [pdf]. Available from http://ash.org.uk/files/documents/ASH_107.pdf*

**The Cost of Smoking to the Cumbria Economy**

ASH (2015) The Local Cost of Tobacco – ASH Ready Reckoner May 2015 Update - estimates the smoking population of Cumbria is around 73,000, based on a prevalence estimate of 18.1%. It is estimated that this incurs the following costs:

- The estimated smoking cost for Cumbria is £128million
- Every year smoking-related early deaths in Cumbria result in 1,512 years' of lost productivity. This costs the Cumbria economy approximately £29million
- It is estimated that smoking breaks cost businesses in Cumbria a further £56million annually
- Local businesses also lose approximately 87,980 days of productivity every year due to smoking-related sick days. This costs about £8million
- The total annual cost to NHS trusts across Cumbria as a direct result of smoking-related ill health is approximately £18million
- Current and ex-smokers who require care in later life as a result of smoking-related illnesses cost society an additional £12.3million each year across Cumbria, representing £7.1million in costs to local authorities.

## 6.2 Who is at risk & why?

National trends indicate that:

- Women are more likely to never or occasionally smoke than men, however the increase in the percentage of never or only occasionally smokers is larger among men than women.
- In 2010, men smoked a higher number of cigarettes a day than women, with men smoking on average 13.3 cigarettes a day, compared with 12.1 for women
- The highest levels of smoking before or during pregnancy were found among mothers in routine and manual occupations, and among those aged under 20.
- Those who were divorced or separated were around twice as likely to be heavy smokers (20 or more cigarettes a day) than those who were single and two and a half times as likely as those who were married/cohabiting or widowed.
- Among both men and women, cigarette smoking prevalence is highest among the lowest income households.

*Source: Health and Social Care Information Centre (2013) Statistics on Smoking: England, 2013 [pdf]. Available from: http://www.hscic.gov.uk/catalogue/PUB11454/smok-eng-2013-rep.pdf*

## 6.3 What is the level of need and gaps?

**Smoking Prevalence**

The Integrated Household Survey (IHS) reported that in 2013 the prevalence of smoking among persons aged 18 years and over was 18.1% in Cumbria; this was similar to the national average of 18.4%. None of Cumbria's districts had significantly worse smoking prevalence rates than the national average in 2013, with South Lakeland having a significantly better rate than the national average (14.1%).

The IHS shows that there are clear differences in smoking prevalence between socioeconomic groups. The IHS reports that those in routine and manual occupations are more likely to smoke. In Cumbria the smoking prevalence rate for this occupation group was 27.6% in 2013; which was similar to the national average of 28.6%. Because of the small sample sizes of the IHS it is not reliable to compare prevalence rates over time.

**Acorn Socio-Economic Profiling**

Acorn estimates 20.6% of UK residents currently smoke (© 1979 – 2015 CACI Limited. This data shall be used solely for academic, personal and/ or non-commercial purposes). However, Acorn also reports that levels of smoking vary considerably across socio-economic types so that, of the 62 Acorn types, the estimated proportion of current smokers is greatest within Acorn Type 52 (Poorer families, many children, terraced housing) postcodes (44.3% prevalence rate). For a detailed description of any Acorn category, group or type, please see: http://acorn.caci.co.uk/downloads/Acorn-User-guide.pdf

Figure 6 presents the estimated proportions of current smokers for the UK, Cumbria and districts based on the Acorn socio-economic profile of these geographies.

Figure 6: Estimated Proportion of Residents: Current Smokers: Based on Propensity of Acorn Socio-Economic Types in Area:

| | Currently Smoke |
|---|---|
| UK | 20.6 |
| Cumbria | 20.8 |
| Allerdale | 21.8 |
| Barrow-in-Furness | 24.7 |
| Carlisle | 22.5 |
| Copeland | 23.0 |
| Eden | 15.8 |
| South Lakeland | 16.5 |



Based on the Acorn type profile of Cumbria's residents, the county has a similar estimated proportion of current smokers (Cumbria 20.8% vs. UK 20.6%). Of Cumbria's districts, Barrow-in-Furness has the greatest estimated proportion of current smokers (24.7%).

At a sub-district level the variation in estimated proportions of current smokers was more substantial. Figure 7 lists the five wards in Cumbria with the greatest estimated proportions of current smokers based of the Acorn socio-economic profile of these wards.

Figure 7: Cumbria Top 5 Wards: Greatest Estimated Proportions of Current Smokers: Based on Acorn Socio-Economic Profile of Ward:

| District | Ward Name | % Residents: Currently Smoke |
|---|---|---|
| Allerdale | Moss Bay | 36.3 |
| Barrow-in-Furness | Central | 34.2 |
| Allerdale | Moorclose | 33.8 |
| Allerdale | Ewanrigg | 33.8 |
| Barrow-in-Furness | Hindpool | 33.7 |



**Smoking in Pregnancy**

PHE Local Tobacco Profiles report that in 2013/14 13.8% of pregnant women in Cumbria smoking at the time of delivery; this is significantly worse than the national average of 12%. Smoking is a significant risk factor that contributes to low birth weight babies. Smoking in pregnancy is strongly correlated with socioeconomic status, with women of lower education, income and employment being more likely to continue smoking than those from higher socioeconomic groups.

**Smoking Related Ill Health**

PHE Local Tobacco Profiles report that in 2013/14 Cumbria had a rate of 2,063 smoking attributable hospital admissions in people aged 35 and over per 100,000 population; this was significantly worse than the national rate of 1,645 per 100,000 population. Furthermore, all of Cumbria's districts except Eden had worse rates than the national average.

**Smoking Attributable Mortality**

Cumbria's previous JSNA highlighted that smoking was the single greatest avoidable cause of premature death across the county.

Public Health England's (PHE) Local Tobacco Profiles (http://www.tobaccoprofiles.info/) report that in 2011/13 an estimated 296.5 deaths in Cumbria were attributable to smoking per 100,000 population (aged 35+); this was similar to the national average of 288.7 per 100,000 population. However, the county average masks variation between districts; with Allerdale, Barrow-in-Furness, Carlisle and Copeland all having significantly worse rates than the national average, while Eden and South Lakeland's rates were better than the national average.

**Smoking Cessation**

In 2014/15 smoking cessation services included stop smoking services for part of the year (until September 2014) and provision in pharmacies throughout the year. Cumbria recorded over 2000 people setting a quit date and 49% of them successfully quitting. Females aged 18-34 and 45-59 years were the people with highest figures for setting a quit date. Males and females aged 45 years and over had a slightly higher percentage that successfully quit (>50%) compared to younger people. Of the 73 pregnant women who set a quit date with the smoking cessation service 32 women successfully quit.

**Gaps**

It would be useful to understand more about e-cigarette use in Cumbria, in particular:

- Level of use
- Use by non-smokers
- Smoking status/change to smoking status in e-cigarette users
- Professional views on e-cigarette use

## 6.4 Current Services and Assets including projections

Stop Smoking support is provided at pharmacies through a range of interventions, including one to one sessions and telephone support.

Every community midwife in Cumbria is now trained to offer a pregnant smoker a test for carbon monoxide, which can damage the unborn child and mother. If the test shows that the woman is a smoker, she will be offered an appointment with a trained assistant midwife smoking advisor. This advisor can support her to stop smoking beyond the delivery of the baby.

## 6.5 Evidence of what works

Information from Department of Health. (2008). Excellence in tobacco control provides the 10 high impact changes to achieve tobacco control:

1: **Work in partnership** e.g. develop a Tobacco Control Alliance

2: **Gather and use the full range of data to inform tobacco control** – to ensure that efforts are focused in the right places

3: **Use tobacco control to tackle health inequalities** - Interventions targeted at the substantially untapped group of smokers within the routine and manual group must be a priority

4: **Deliver consistent, coherent and co-ordinated communication** e.g. local smokefree campaigns

5: **An integrated stop smoking approach** – local Stop Smoking Services should be viewed as just one element of an overall strategic and comprehensive programme

6: **Build and sustain capacity in tobacco control** – create infrastructure, resources and political will

7. **Tackle cheap and illicit tobacco** - greater effort to reduce both the demand and supply of cheap illicit tobacco.

8: **Influence change through advocacy** – changing the political, economic and social conditions that encourage tobacco use and gain public, political and media support for tobacco-related issues.

9: **Help young people to be tobacco free** - youth prevention should be part of a comprehensive tobacco control programme

10: **Maintain and promote smoke free environments** – e.g. support new legislation around smoke free vehicles

Available from:
http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_084848.pdf

## 6.6 User views

ASH has produced regional summaries of the Smokefree Britain Survey 2015: http://ash.org.uk/localtoolkit/docs/R2-NW/PO-R2-NW.pdf. The North West summary indicates that:

- Support for recent measures introduced by the Government to tackle the harm caused by tobacco is very high in the North West. Support for the ban on smoking in cars carrying children younger than 18 years of age is particularly high at 84%, this becomes law in October 2015.
- Adults in the North West see a need for greater action to control tobacco, with the introduction of a positive tobacco licencing scheme particularly popular.
- Smoking in the home - In this survey, 82% adults in the North West said that they do not allow smoking anywhere in their home or only in places that are not enclosed (such as in the garden or on a balcony). Only a minority (9%) stated that they would allow smoking anywhere in their house, or only in some rooms (9%).
- When asked where they purchase cigarettes/tobacco from, 78% of respondents in the North West said they were not purchasing tobacco through illicit channels, with 12% making some illicit purchases. A minority (8%) purchase tobacco only through illicit channels. In addition, there is very strong public support for measures to curb the illicit trade; in the Smokefree Britain survey in 2014 only 4% of respondents in the North West opposed measures to crack down on tobacco smuggling

# 7 Healthy Weight and Healthy Eating

## 7.1 What is the population overview?

The World Health Organisation (WHO) definition of overweight and obesity is:

- a BMI greater than or equal to 25 is overweight
- a BMI greater than or equal to 30 is obesity.

Public Health England (2015) highlight the following key issues regarding overweight and obesity in adults:

- two thirds of adults are overweight or obese. More adults are now severely obese.
- a high Body Mass Index (BMI) is costly to health and social care and has wider economic and societal impacts.

Adults who are overweight and obese are:

- Less likely to be in employment
- More likely to experience discrimination and stigmatisation
- More likely to be hospitalised
- Likely to die on average 3 years earlier (severe obesity reduces it by 8-10 years)

Obesity is complex, as shown in figure 8 below (PHE, 2015). Factors such as food supply, societal influences, physical activity levels, psychology and genetics all contribute towards a person's propensity to be overweight or obese.

**Figure 8: Complex range of factors that contribute towards overweight and obesity**

Being overweight and obese is associated with:

- Depression and anxiety
- Sleep apnoea
- Asthma
- Osteoarthritis and back pain
- Type 2 diabetes
- Reproductive complications
- Heart disease and stroke
- Cancer
- Liver disease

Particular issues regarding obesity:

- Adults tend to underestimate their own weight
- The media tend to use images of extreme obesity to illustrate articles about obesity
- GPs may underestimate their patient's BMI

Obesity costs the wider economy £27bn including:

- Obesity medication - £13.3m
- Obesity attributed days sickness - £16m
- Social Care - £352m
- Cost to NHS - £5.1bn

Source: Public Health England (2015) Making the case for tackling obesity: why invest? Available from: https://www.noo.org.uk/slide_sets

## 7.2 Who is at risk & why?

Obesity is more common amongst the following groups (PHE, 2015):

**Age:**

The prevalence of overweight and obesity increases with age for both men and women, with the highest prevalence being seen in the 65-74 age group. After this age, obesity prevalence decreases (National Obesity Observatory, 2011).

**Ethnicity:**

Obesity prevalence tends to be higher in some black and minority ethnic groups

**Socioeconomic status:**

People from deprived areas are more likely to be overweight and obese.

**Disability:**

There are associations between limiting longstanding illness and BMI. For men, 16% of those with a healthy weight have a limiting, longstanding illness compared with 29% of obese men. In women, the rates are 17% for healthy weight and 36% for obese women (Department of Health, 2008).

Obesity disproportionately affects people with a learning disability. Approximately one adult in three with a learning disability is obese compared to one in five in the general population (Disability Rights Commission, 2005).

## 7.3 What is the level of need and gaps?

**Excess weight**

The Active People Survey in 2012 recorded adult excess weight and in Cumbria 68.3% of the population is estimated to be overweight and this is significantly higher than England which is 63.8%. In the survey Copeland district reported the highest proportion of adults overweight at 75.9%. The districts Carlisle and Eden also have a proportion overweight greater than England, 68.4% and 68.8%.

**Obesity in Adults**

GPs record those over 16 years who have a BMI over 30 in the preceding 12 months. The prevalence ranges from 1.41% and 18.58% in Cumbria CCG practices compared to 9.84% across England. The 3 practices with a prevalence over 16% are based in Maryport, Workington (Disington) and Whitehaven.

**Acorn Socio-Economic Profiling**

Acorn estimates that across UK residents, 21.1% have a BMI greater than 30, (© 1979 – 2015 CACI Limited. This data shall be used solely for academic, personal and/ or non-commercial purposes). However, Acorn also reports that levels of obesity vary considerably across socio-economic types so that, of the 62 Acorn types, the estimated proportion of residents who have a BMI greater than 30 is greatest within Acorn Type 46 postcodes (Elderly people in social rented flats) (39.8%). For a detailed description of any Acorn category, group or type, please see: http://acorn.caci.co.uk/downloads/Acorn-User-guide.pdf

Figure 9 presents the estimated proportions of residents who have a BMI greater than 30 for the UK, Cumbria and districts based on the Acorn socio-economic profile of these geographies.

Figure 9: Estimated Proportion of Residents: BMI Greater than 30: Based on Propensity of Acorn Socio-Economic Types in Area:

| | BMI > 30 |
|---|---|
| UK | 21.1 |
| Cumbria | 22.8 |
| Allerdale | 23.1 |
| Barrow-in-Furness | 24.0 |
| Carlisle | 23.1 |
| Copeland | 23.2 |
| Eden | 21.8 |
| South Lakeland | 21.8 |



Based on the Acorn type profile of Cumbria's residents, the county has a slightly higher estimated proportion of residents with a BMI greater than 30 (Cumbria 22.8% vs. UK 21.1%). Of Cumbria's districts, Barrow-in-Furness has the greatest estimated proportion of residents with a BMI greater than 30 (24%).

Figure 10 lists the five wards in Cumbria with the greatest estimated proportions of residents with a BMI greater than 30 based of the Acorn socio-economic profile of these wards.

Figure 10: Cumbria Top 5 Wards: Greatest Estimated Proportions: BMI Greater than 30: Based on Acorn Socio-Economic Profile of Wards:

| | District | Ward Name | % Residents: Displaying Characteristic |
|---|---|---|---|
| BMI > 30 | Barrow-in-Furness | Hindpool | 26.9 |
| | Eden | Penrith Pategill | 26.6 |
| | Barrow-in-Furness | Central | 26.4 |
| | Carlisle | Morton | 25.7 |
| | Allerdale | Moss Bay | 25.7 |



**Food, Nutrition and Healthy Eating**

The importance of diet as a major contributor to chronic disease and premature death in England is recognised in the White Paper 'Healthy Lives, Healthy People'. Poor diet is a public health issue as it increases the risk of some cancers and cardiovascular disease (CVD), both of which are major causes of premature death. These diseases and type II diabetes (which increases CVD risk) are associated with obesity. The costs of diet related chronic diseases to the NHS and more broadly to society are considerable. Poor diet is estimated to account for about one third of all deaths from cancer and CVD.

A quarter of adults in England are obese (England Health Survey 2013). Average intakes of saturated fat, sugar, and salt are above recommendations while intakes of fruit and vegetables, fibre and some vitamins and minerals are below recommendations. In Cumbria in 2014 58.3% of people reported that on the previous day they had eaten 5 portions of fruit and vegetables this is higher than the national average at 53.5%. The highest consumption of the number of people reporting that they had eaten 5 portions of fruit and vegetables is Eden at 64.4% and the lowest is Barrow at 52.3%.

**Figure 11: Fruit and Vegetables '5 a day' consumption**

| | |
|---|---|
| **Allerdale** | 60.6% |
| **Barrow-in-Furness** | 52.3% |
| **Carlisle** | 53.5% |
| **Copeland** | 55.8% |
| **Eden** | 64.4% |
| **South Lakeland** | 63.5% |
| **Cumbria** | 58.3% |
| **England** | 53.5% |

Figure 12 shows the number of people in the six local authority areas in Cumbria answered the question 'How many portions of fruit did you eat yesterday? Please include all fruit, including fresh, frozen dried or tinned fruit, stewed fruit or fruit juices and smoothies' in the Active People Survey 2014. The data shows that in Cumbria people reported that on average on the previous day 2.75 portions of fruit were eaten. This is higher than the national average 2.58. Figure 12 shows that the highest reported portions of fruit eaten was in Eden at 2.96 and the lowest was in Carlisle at 2.48 portions.

**Figure 12: Average Portions of Fruit Eaten**

| | |
|---|---|
| **Allerdale** | 2.87 |
| **Barrow-in-Furness** | 2.57 |
| **Carlisle** | 2.48 |
| **Copeland** | 2.77 |
| **Eden** | 2.96 |
| **South Lakeland** | 2.90 |
| **Cumbria** | 2.75 |
| **England** | 2.58 |

Figure 13 shows the number of people in the six local authority areas in Cumbria answered the question 'How many portions of vegetables did you eat yesterday? Please include fresh, frozen, raw or tinned vegetables, but do not include any potatoes you ate' in the Active People Survey 2014. The data shows that in Cumbria people reported that on average on the previous day 2.45 portions of vegetables were eaten this is higher than the national average 2.27. Figure 13 shows that the highest reported portions of vegetables eaten was in South Lakeland at 2.61 and the lowest was in Barrow 2.26 at portions.

**Figure 13: Average Portions of Vegetables Eaten**

| | |
|---|---|
| **Allerdale** | 2.58 |
| **Barrow-in-Furness** | 2.26 |
| **Carlisle** | 2.38 |
| **Copeland** | 2.36 |
| **Eden** | 2.36 |
| **South Lakeland** | 2.61 |
| **Cumbria** | 2.45 |
| **South Lakeland** | 2.27 |

Overweight and obesity in adults is predicted to reach 70% by 2034 (PHE, 2015). Between 2010 and 2030, healthcare costs linked to obesity are likely to rise by £2bn.

The following additional needs analysis would be useful:

- Modelling demand for a county-wide tier 3 specialist weight management service (Cumbria Clinical Commissioning Group currently reviewing provision at this level)
- Further qualitative exploration into people's views re: obesity

## 7.4 Current Services and Assets including projections

The following services are currently provided in Cumbria that support healthy weight in adults:

| Service | Commissioner | Provider | Description |
|---|---|---|---|
| Health Checks | Cumbria County Council | Primary Care | People aged between 40-74 are called for a health check every 5 years (if not already on a disease register). Check includes an assessment of BMI and information about healthy lifestyles |
| Exercise on Referral | Cumbria County Council/Clinical Commissioning Group (CCG) | Leisure Trusts | Adults can be referred to local leisure trusts to take part in subsidised physical activity under the supervision of a qualified fitness instructor |
| Healthy Living Pharmacy | Cumbria County Council | Pharmacies | Pharmacists are trained as Healthy Living Champions in order to provide information and guidance regarding healthy weight |
| Tier 2 weight management programme | Cumbria County Council | Range of providers | Primary care and social care practitioners can refer people for 12 weeks of free weight management support (if BMI is 25 or over with comorbidities, or 30+ without comorbidities). Currently being piloted during 2015 |
| Dietetics | CCG | Cumbria Partnership Foundation Trust | Specialist advice around diet for people with particular medical needs |

| | | | |
|---|---|---|---|
| Tier 4 Bariatric Surgery | NHS England | University Hospital Aintree, Liverpool | Weight loss surgery for individuals with very high BMIs and complex comorbidities |

**Gaps**

The following needs may be unmet, based on current service provision:

- Structured universal provision of clear information and advice regarding healthy weight
- Tier 2 provision for males (the current tier 2 model being piloted appears to be predominantly being accessed by women, which is expected for this type of programme (see current services)
- Tier 3 provision – there is currently no specialist support available for people with a very high BMI (typically 35+) with co-morbidities

## 7.5 Evidence of what works

Public Health England provide information around evidence of what works:

- In 2011-12, the Glasgow Health Walks project led to a return on investment of £8 for every £1 spent
- For every participant on a 12 session commercial weight management programme, the NHS stands to save £230 over a lifetime
- Birmingham's 'Be Active' programme returned up to £23 in benefits for every £1 spent in terms of quality of life, reduced NHS use, productivity and other gains to the local authority
- Middlesbrough Environment City staff health and wellbeing programme reduced annual sickness rate per employee from 4.23 days to 2.4 days
- Getting one person to cycle to work rather than go by car could generate between £539 and £641 in savings

Sustained changes to individual behaviours across the whole population requires:

- Multiple actions across all parts of the system
- Changes to the food, physical activity and social environments
- All sectors have a role to play in supporting healthy weight (see figure x)

Source: Public Health England (2015) Making the case for tackling obesity: why invest? Available from: https://www.noo.org.uk/slide_sets

The following figure details the partnerships that are recommended to be involved to tackle obesity:

**Figure 14: Partnerships – who needs to be involved**


Source: Public Health England (2015) Making the case for tackling obesity: why invest? Available from: https://www.noo.org.uk/slide_sets

## 7.6 User views

There is not cumbria wide user views of healthy diet and weight available. A recent stakeholder engagement workshop held in Maryport (March, 2015), as part of the work of the Maryport Health Assets Group, involved representatives of local patient and residential groups. In response to the question 'what do you think encourages people to have an unhealthy weight?' the following key issues were raised:

- Because it is accepted as the norm now
- Lack of understanding about portion size
- Forget about simple family pleasures such as walking, riding, and skipping
- A lack of options for buying healthy food alternatives and cost
- Low culinary skills and knowledge
- Convenience store on the estate – cheap calories
- Low self-esteem and low finances
- Lack of food choice locally
- Too easy to make fast food
- Social acceptability. Being thin equated to being unhealthy
- There are no long term commitments which address sustainability for programmes
- Lack of fun. Accessible activities on people's doorstep suitable for all abilities, not just sporty people. Challenges (red tape, cost, capacity) of providing this
- Some people struggling to feed their families on benefits
- Culture
- Fast food outlets
- Not understanding what is healthy and what isn't
- Disadvantaged families may be prone to low mood causing comfort eating

# 8 Physical Activity

## 8.1 What is the population overview?

**The impact of physical activity on health:**

Physical activity is described as body movement that expends energy and raises the heart rate. Inactivity is classed as less than 30 minutes of physical activity a week, and sedentary time means time spent in low-energy postures, e.g. sitting or lying.

*Source: Public Health England, Everybody Active Every Day – An evidence based approach to physical activity, October 2014. Available from*
*https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/353384/Everybody_Active__Every_Day_evidence_based_approach_CONSULTATION_VERSION.pdf*

Globally, physical inactivity is the fourth leading risk for mortality (accounting for 6% of deaths). This follows high blood pressure (13%), tobacco use (9%) and high blood glucose (6%). Overweight and obesity are responsible for 5% of global mortality.

*Source: Department of Health, Start Active Stay Active, July 2011. Available from*
*https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216370/dh_128210.pdf*

It has been estimated that physical inactivity leads to around 37,000 premature deaths a year in England alone. Despite the multiple health gains with a physical active lifestyle, there are high levels of inactivity in England.

*Source: Public Health England, Health Impact of Physical Inactivity, June 2013. Available from*
*http://www.apho.org.uk/resource/view.aspx?RID=123459*

In the UK, physical inactivity directly contributes to one in six deaths.

*Source: Public Health England, Everybody Active Every Day – An evidence based approach to physical activity, October 2014. Available from*
*https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/353384/Everybody_Active__Every_Day_evidence_based_approach_CONSULTATION_VERSION.pdf*

**Economic / health cost of physical inactivity**

According to Sport England, the estimated figure that physical inactivity costs the national economy in healthcare, premature deaths and sickness absence amounts to £7.4bn. Furthermore, £1,760-£6,900 can be saved in healthcare costs per person by taking part in sport.

*Source: Sport England, Partnering Local Government, Local sports Data, October 2014. Available from*
*https://www.sportengland.org/our-work/local-work/partnering-local-government/local-sports-data/*

**UK Physical Activity Guidelines**

In June 2011, the Chief Medical Officer published guidelines on physical activity for different age groups, which include:

Adults:

- All adults aged 19 years and over should aim to be active daily.
- Over a week, this should add up to at least 150 minutes (2.5 hours) of moderate intensity physical activity in bouts of 10 minutes or more.
- Alternatively, comparable benefits can be achieved through 75 minutes of vigorous intensity activity spread across the week or combinations of moderate and vigorous intensity activity.
- All adults should also undertake physical activity to improve muscle strength on at least 2 days a week.
- They should minimise the amount of time spent being sedentary for extended periods.
- Older adults (65 years and over) who are at risk of falls should incorporate physical activity to improve balance and coordination on at least 2 days a week.
- Individual physical and mental capabilities should be considered when interpreting the guidelines, but the key issue is that some activity is better than no activity.

Children and Young People:

- Children of pre-school age who are capable of walking unaided should be physically active daily for at least 180 minutes (3 hours), spread throughout the day.
- All children should undertake a range of moderate to vigorous intensity activities for at least 60 minutes over the course of a day.
- Children aged 5 years and over should undertake vigorous intensity activities, including those that strengthen muscle and bone, at least 3 days a week.
- All children should minimise the amount of time they spend being sedentary (being restrained or sitting) for extended periods (except time spent sleeping).
- It is beneficial for parents and carers to get involved in physical activities with their children and to complete at least some local journeys (or some part of a local journey) with young children using a physically active mode of travel with the aim of establishing active travel as a life-long habit from an early age.

The Health Survey for England 2012 found that, based on self-reporting, 67% of men and 55% of women aged 16 and over met the Department of Health's UK physical activity guidelines. However, people often overestimate the amount of physical activity they undertake, meaning the real figures may be lower. The survey also found that 26% of women and 19% of men were classed as 'inactive'.

For children, the Health Survey for England 2012 found that, based on self-reporting, 21% of boys and 16% of girls aged 5–15 years met the UK physical activity guidelines for children and young people. Among both sexes, the proportion meeting the recommendations in the guidelines was lower in older children. For boys and girls aged 2–4 years, a similar proportion (9% and 10% respectively) was classified as meeting the UK physical activity guidelines. In this age group, 84% of children fell into the 'low activity' group, meaning that they did less than an hour of activity a day, or did not do sufficient activity each day.

*Source: Health & Social Care Information Centre, Health Survey for England 2012. Available from http://www.hscic.gov.uk/catalogue/PUB13218*

**Physical activity and the prevention of chronic conditions**

The benefits of regular physical activity have been clearly set out across the life course. In particular, for adults, doing 30 minutes of at least moderate intensity physical activity on at least 5 days a week helps to prevent and manage over 20 chronic conditions, including coronary heart disease, stroke, type 2 diabetes, cancer, obesity, mental health problems and musculoskeletal conditions. The strength of the relationship between physical activity and health outcomes persists throughout people's lives, highlighting the potential health gains that could be achieved if more people become more active throughout the life course.

## 8.2 Who is at risk & why?

Although Physical Inactivity is an issue for the whole population and transcends across many demographics evidence suggests that the following groups are at the greatest risk;

**Gender**

- Women are at a greater risk as levels of Physical Inactivity are much higher amongst women than men; 45% of women do not meet the government's recommended levels for Physical Activity in relation to 33% of men.

*Source: Public Health England, Everybody Active Every Day – An evidence based approach to physical activity, October 2014.*

**Age**

- Physical Inactivity continues to grow amongst children and young people especially amongst girls. Between 2008 and 2012, the proportion of children aged two to 15 years meeting the recommended physical activity levels fell from 28% to 21% for boys and 19% to 16% for girls.

*Source: Public Health England, Everybody Active Every Day – An evidence based approach to physical activity, October 2014.*

- Young People are also becoming increasingly more sedentary and this becomes more prevalent within the teenage years.

Source: Health Survey for England 2012

- Physical activity declines with age to the extent that by the age of 75 years only one in ten men and one in 20 women are active enough for good health and due to the ageing population within Cumbria this presents a considerable risk. Again this is even more prevalent within women.

Source: *Public Health England, Everybody Active Every Day – An evidence based approach to physical activity, October 2014.*

**Socio-economic Status**

- There are greater levels of Physical Inactivity in socially disadvantaged areas; evidence suggests that the areas of highest deprivation are almost 10 per cent more physically inactive than the lowest deprivation areas.

*Source: UK Active: Turning the Tide of Inactivity, January 2014*

**Disability**

Nationally adults with a disability are half as likely to take part in sport on a regular basis. Only 18% of adults with a disability regularly take part in sport compared to 39% of non-disabled adults.

*Source: Health Survey for England 2012*

## 8.3 What is the level of need and gaps?

**Current sport participation, health and economic data in Cumbria**

The following tables below show the key sport, health and economic data for sports participation across the districts of Cumbria and comparisons to national averages.

Table 1: % of adults (16+) who report undertaking 150 minutes of moderate intensity physical activity:

| Allerdale | Barrow-in-Furness | Carlisle | Copeland | Eden | South Lakeland | Cumbria | England |
|---|---|---|---|---|---|---|---|
| 57.6 | 52.3 | 50.4 | 55 | 65 | 59.6 | 56.3 | 55.6 |

*Source: Public Health Outcomes Framework (2014)*

Although the percentage of adults (16+) who report undertaking 150 minutes of moderate intensity physical activity for Cumbria is higher than the national average, some of the districts e.g. Barrow-in-Furness and Carlisle are significantly below the national average.

Table 2: % of adults (14+) who take part in sport at least once a week

| | Allerdale | Barrow-in-Furness | Carlisle | Copeland | Eden | South Lakeland | Cumbria | England |
|---|---|---|---|---|---|---|---|---|
| Overall | 38.8 | 29.8 | 35.9 | 40.6 | 34.2 | 32.2 | 35.2 | 36.7 |
| • Men | 47.8 | 35.1 | 37.9 | 56.2 | 34.5 | 33.3 | 40.5 | - |
| • Women | 29.6 | 24.6 | 34 | 25.7 | 33.8 | 31 | 30.1 | - |

*Source: Sport England Active People Survey 7/8 (April 2013-Apr 14) (published June 2014)*

The districts of Allerdale and Copeland show a higher percentage of adults who take part in sport at least once a week than the average for Cumbria and England. In both of these districts the percentages of men taking part in sport are significantly higher than women. However, all districts show this trend.

Table 3: % of adults (16+) who take in sport and active recreation three times a week

| | Allerdale | Barrow-in-Furness | Carlisle | Copeland | Eden | South Lakeland | Cumbria | England |
|---|---|---|---|---|---|---|---|---|
| Overall | 30.4 | 25.1 | 26.3 | 30.6 | 29 | 27.2 | 29.5 | 26 |
| • Men | 36.5 | 30 | 29.2 | 41.2 | 29 | 30.3 | 34.3 | - |
| • Women | 26.4 | 20.4 | 23.6 | 23.6 | 29.2 | 25.4 | 27 | - |

*Source: Sport England Active People Survey 7/8 (April 2013-Apr 14) for county councils and April 2012- Apr 2014 for district and unitary authorities) (published June 2014)*

The majority of districts show higher than national averages (expect for Barrow-in-Furness) for the percentage of adults who take part in sport and active recreation three times a week. The trends are similar to those as was shown in Table 2.

Table 4: % of adults (16+) who are inactive

| Allerdale | Barrow-in-Furness | Carlisle | Copeland | Eden | South Lakeland | Cumbria | England |
|---|---|---|---|---|---|---|---|
| 30.8 | 36.1 | 35.1 | 32.6 | 24.1 | 28.2 | 31.3 | - |

*Source: Public Health Outcomes Framework (2014)*

The percentage of adults who are inactive is higher in Barrow-in-Furness and Carlisle, in comparison the figure for Cumbria.

Table 5: % of adults who are inactive, but want to take part in sport

| Allerdale | Barrow-in-Furness | Carlisle | Copeland | Eden | South Lakeland | Cumbria | England |
|---|---|---|---|---|---|---|---|
| 39.4 | 43.7 | 38.4 | 52.6 | 39.4 | 41.2 | 41.7 | - |

*Source: Sport England Active People Survey 7/8 (April 2013-Apr 14) (published June 2014)*

The above table demonstrates there is a significant opportunity and latent demand to increase participation among those that are identified as inactive.

Table 6: Number of deaths estimated to be prevented per year if 75% of the population aged 40-79 were engaged in the recommended levels of physical activity

| Allerdale | Barrow-in-Furness | Carlisle | Copeland | Eden | South Lakeland | Cumbria | England |
|---|---|---|---|---|---|---|---|
| 58 | 45 | 60 | 44 | 25 | 55 | 287 | - |

*Source: Association of Public Health Observatories/Public Health England Health Impact of Physical Activity (2013)*

Table 7: Estimated health costs of inactivity

| Allerdale | Barrow-in-Furness | Carlisle | Copeland | Eden | South Lakeland | Cumbria | England |
|---|---|---|---|---|---|---|---|
| £1.7m | £1.3m | £1.9m | £1.3m | £1m | £1.9m | £9.1m | - |

*Source: Sport England commissioned data from British Heart Foundation Health Promotion Research Group. For years 2009/10. Published 2012*

Table 8: Economic value of improved quality and length of life plus health care costs avoided

| Allerdale | Barrow-in-Furness | Carlisle | Copeland | Eden | South Lakeland | Cumbria | England |
|---|---|---|---|---|---|---|---|
| £31.6m | £26.9m | £41.9m | £24.6m | £21.1m | £42.2m | £188.4m | - |

*Source: Sport England's 'Economic Value of Sport – Local Model'*

**Gaps in understanding need**

- There is currently no up to date robust data available at a local level which details physical activity participation levels in children and young people. The most recent data produced was the 2009 Tell4All, 2010 National School Sport Survey and 2012 – Cumbria Health Related Behaviour Survey.

- Equality Impact Assessments may be required with regards to current service provision.

## 8.4 Current Services and Assets including projections

There is currently a selection of preventative and targeted services provided to address Physical Inactivity which include the following;

Preventative services are those which are accessible to all participants and provide a universal offer. These include;

- Recreational Cycling Programme
- Health Walks across specific areas of the County

Targeted services are those which may be accessed by specific populations and those who may require additional support. Services include;

- Exercise on Referral which is currently jointly commissioned through the Cumbria Clinical Commissioning Group and Cumbria County Council. The scheme operates across four localities until March 2016 providing opportunities for Adults who are currently inactive to be referred to local leisure providers to participate in a supported Physical Activity Programme.
- Tier 3 Physical Activity sessions commissioned by the Cumbria Clinical Commissioning Group including Cardiac Rehabilitation, Pulmonary Rehab and Falls Prevention. Further clarity is required regarding the extent of coverage.
- AGE UK provide chair based exercise classes and health walks in specific areas of the County.
- A number of pilot initiatives are in development to address Physical Inactivity in specific populations. Interventions are however time and resource limited. A longer term approach towards Physical Activity provision is required.
- Sport England funded programmes commissioned until 2017 targeted at specific user groups.

In regard to projections evidence states that as a nation we are 20% less active than in 1961 and should this current trend continue we will be 35% less active by 2030.

The current statistics in relation to Physical Inactivity highlight that this is unsustainable and costs the UK an estimated £7.4bn a year. If current trends continue, the increasing costs of health and social care will destabilise public services and take a toll on the quality of life for individuals and communities.

Source: *Public Health England, Everybody Active Every Day – An evidence based approach to physical activity, October 2014.*

**Gaps in Services**

- Uncertainty remains surrounding Exercise on Referral options post March 2016, this currently does not provide a universal service across the County with gaps existing within South Lakeland and Barrow in Furness.
- County wide access to a Tier 3 Secondary prevention exercise scheme (subject to the provision of further information/insight).Workplace Health initiatives across a range of employers.
- County wide Physical Activity Interventions to support individuals with disabilities to increase their participation levels.
- Funding has previously been secured to support Physical Activity interventions within specific localities with areas of high deprivation however participation levels across all areas of the County require improvement.

## 8.5 Evidence of what works

Public Health England in partnership with National and Local Stakeholders have co-produced the Physical Activity Framework *Everybody Active Every Day,* a culmination of national and international evidence on 'what works' across all sectors and levels for increasing physical activity in England. The Framework draws upon the 9 existing NICE guidelines that specifically focus upon Physical Activity.

It is advocated that the following works;

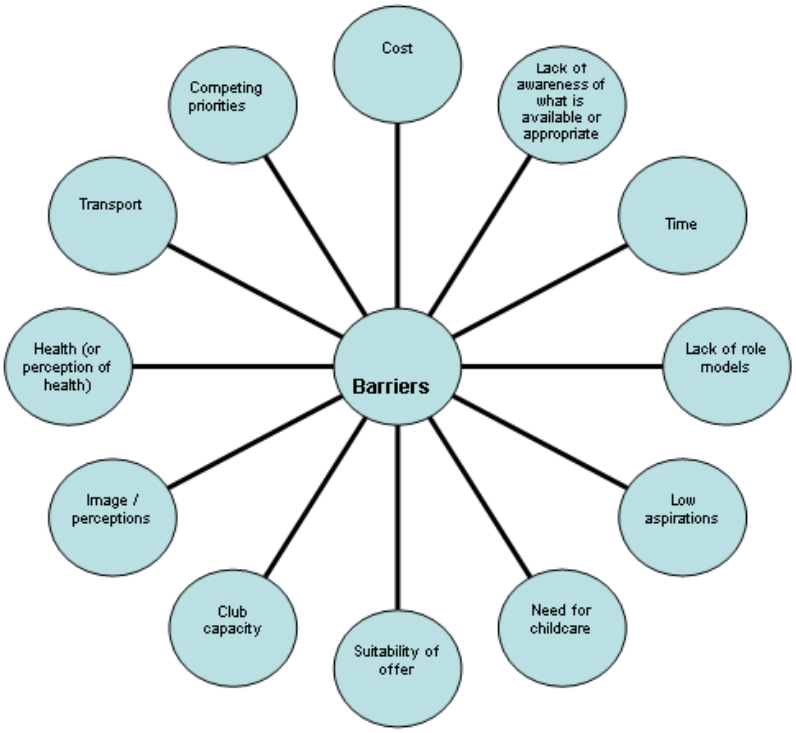
- Prioritising the creation and maintenance of the Physical environment i.e. improving and maximising green spaces, creating safe routes to school in order to encourage and provide greater opportunities for walking and cycling. NICE emphasises the importance of public open spaces in encouraging physical activity.
- Maximising the use of existing assets such as schools and leisure facilities and making spaces available to communities and school children outside of hours.
- Increasing social support for physical activity within communities, specific neighbourhoods, and workplaces can effectively promote physical activity. Specific examples have included free community classes and health walks in public places and fun activity sessions for children and young people. Local initiatives are recognised for supporting less engaged participants such as women, older adults and lower socioeconomic groups.
- Group based interventions are deemed to work well in increasing participation NICE recommends that inactive adults be encouraged to take up walking programmes supported by suitably trained walk leaders.
- Successful facilitated group activities including guided bike rides for people with little or no experience of cycling, such as Sky Ride Locals and the 'parkrun' running interventions are recommended
- Implementation across the life course focusing upon establishing good habits from the onset and focusing upon whole family approaches.
- Targeted and tailored interventions addressing social isolation and involving peer mentoring are most likely to be successful with Older Adults.

*Source: Public Health England, Everybody Active Every Day – An evidence based approach to physical activity, October 2014.*

## 8.6 User views

Physical Inactivity and Sedentary behaviour is influenced by many factors and there are a significant number of barriers which may impact upon an individual's decision whether to participate or not in Physical Activity. The Active Cumbria Strategy for Sports and Physical Activity 2013-2017 highlights the generic barriers influencing participation as depicted in Figure 15 however it should be noted that participation can vary from user to user.

Figure 15: Key Barriers to participation in Sports and Physical Activity




*Source: Active Cumbria: A Strategy for Sports and Physical Activity 2013-2017*

National Evidence based around specific demographics highlights the following;

**Women and Girls**

The Fear of being judged is an important all-encompassing concern. This relates to both the ability to perform effectively and the belief that exercise may be perceived as self-indulgent. The fear of judgement is underpinned by a whole host of other factors including both practical challenges i.e. time, cost, lack of information through to personal barriers such as social confidence and concerns about ability and appearance. Sport England have launched a nationwide campaign 'This Girl Can' which aims to get women and girls moving, regardless of their shape, size and ability. Influenced by insight the campaign seeks to celebrate achievements of women through real life stories as a means of breaking down barriers and increasing participation.

*Sport England: Go where women are – Insight on engaging women and girls in sport and exercise. (2015)*

**Young People**

Attitudes to sport and physical activity are complex for this age range with behaviors varying on a month to month basis and changing considerably through their life course. Participation may be influenced by negative experiences of school sport, fear of being laughed at, peer pressure or the belief that sport is too structured. Some of the recommendations with regards to service design for this group include moving away from purely the notion that sport is 'fun' and focusing upon the wider functional benefits, greater involvement of young people in shaping experiences and offering broader options alongside traditional sports.

*Sport England: The challenge of growing youth participation in sport. (August, 2014)*

**Older People**

Older adults are influenced by a complex range of individual, social and environmental factors including transportation, traffic safety, social support, fear of falling and over exertion through to confidence and risk perception. It is suggested that the design of services should include the use of behaviour change strategies and peer support. Group based physical activity sessions are also proven to be successful.

*BHF Active: Older Adults Physical Activity Briefing (March, 2012)*

**National Partners:**

**Transport and Health Study Group:**

'If physical activity were a drug then the range of its benefits on mental well being, mental illness, heart disease, obesity, diabetes and osteoporosis is such that no politician would dare withhold those benefits from the public. At a time when the NHS struggles to cope with the pressures of mental illness, obesity and diabetes, it is financially irresponsible to fail to promote physical activity.'

**Royal College of Physicians:**

'Often the benefits of physical activity are closely linked to reductions in obesity. The RCP however, strongly recommends that wider benefits of physical activity should be recognised and promoted. Individuals who are obese but have a good level of cardiorespiratory fitness (CRF) can have better health and wellbeing than an individual with an ideal body Mass Index (BMI) but low CRF. The wider health benefits of physical fitness should be promoted to improve the health of the nation.'

**Dr William Bird, A GP with an interest in physical activity and founder of Intelligent Health:**

'Of course obesity is important, but physical activity in its own right has benefits. In fact only 10% of the benefits of physical activity for cardiovascular disease are weight-related. The other 90% are the anti- inflammatory effects - the other aspects of cellular change that take place when you are physically active.'

**House of Commons Health Committee: Impact of physical activity and diet on health – sixth report of session 20140-15 (page 14):**

'For too long, physical activity has been seen merely in the light of its benefits in tackling obesity. However, there is compelling evidence that physical activity in its own right has

huge health benefits totally independent of a person's weight—in fact research recently published suggested that increasing physical activity levels could have greater impact on reducing mortality than reducing weight. The Chief Medical Officer's guidelines recommend levels of activity which will help people derive the greatest health benefits; but even small increases in activity levels can have a dramatic positive impact on health.'

**Sport England:**

Sport England's Market Segmentation toolkit categorises the types of adults who live in a specific area outlining their behaviours and motivations. From a Cumbria perspective the research tells us which particular market segments live in each area of the county, reaching down to lower super output area level, and also provides detailed information on a range of tools and techniques to support getting those within each segment to be more physically active.

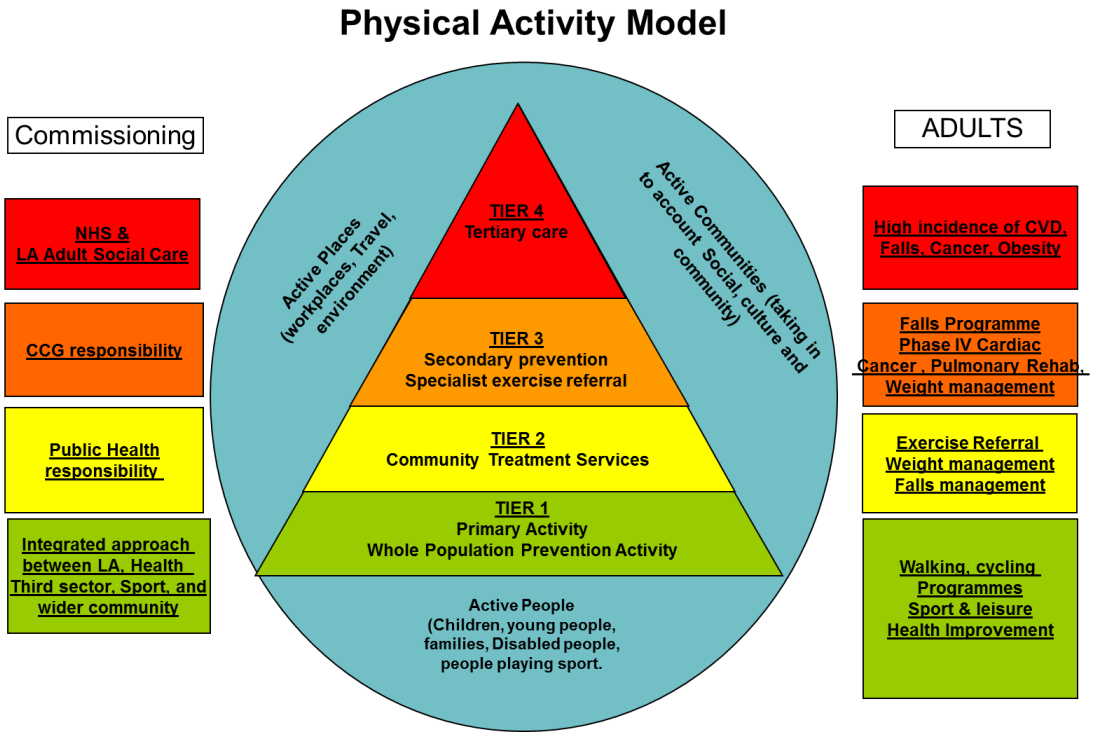
*Source: Sport England Market Segmentation Toolkit*
*http://www.sportengland.org/research/about-our-research/market-segmentation/*

**Priorities**

There is strong evidence to highlight the many benefits Physical Activity brings to the health of individuals as highlighted in Sections 1 & 2 and based upon the evidence provided there is a need to tackle and address sedentary behaviour and Physical Inactivity throughout the life course. It is therefore recommended that;

- Greater clarity and understanding of the different sectors offers which contribute towards Physical Activity and that mapping of the physical activity landscape is undertaken.
- A strong offer in relation to Physical Activity within the Health & Social Wellbeing System with a focus upon effective campaigning and signposting in order to support sustainable lifestyle changes.
- Clear pathways need to be implemented in order to ensure effective and appropriate referrals which should also contain a sustained approach towards lifestyle behaviour changes.
- Opportunities to upscale successful pilots based upon proven, evidenced and successful outcomes.
- Closer engagement and discussion with all planning authorities to facilitate greater opportunities for Active Travel and the effective use of green space within communities.
- The realignment of existing initiatives and commissioned services to support the PHE Physical Activity model as depicted in Figure 16

**Figure 16: Public Health England Physical Activity Model**




*Source: Public Health England*

# 9 Sexual Health

## 9.1 What is the population overview?

Sexual health is influenced by a complex web of factors ranging from sexual behaviour and attitudes and societal factors, to biological risk and genetic predisposition. It includes the problems of HIV and STIs, unintended pregnancy and abortion, infertility and cancer resulting from STIs. Although sexual health has been implicitly understood to be part of the reproductive health agenda, the emergence of HIV and STIs has highlighted the need to focus more explicitly on the promotion of good sexual health. Untreated STIs can lead to serious and painful health consequences, ranging from infertility to cancer.

Most adults in England are sexually active. The 2010 Health Survey for England found the following:

• Of those aged 16 to 69, 92% of men and 94% of women reported that they had ever had sexual intercourse with someone of the opposite sex.

• Of those aged 16 to 69, 80% of men and 79% of women reported that they had had sex with someone of the opposite sex in the past year.

• Men reported an average of 9.3 female sexual partners in their lives so far, while women reported an average of 4.7 male sexual partners.

• Overall, 80% of men and 86% of women reported that they had not had sex with someone of the opposite sex before the age of 16.

• The median age of first sex with someone of the opposite sex was 17 for both men and women.

• Of those aged 16 to 69, 1.6% of men and 1.8% of women reported that they had had sex with someone of the same sex in the past five years.

Statistics detailed in the sexual health framework (Department of Health, 2013) for improvement outlines areas around sexual health that highlight some of the issues:

• Up to 50% of pregnancies are unplanned; these have a major impact on individuals, families and wider society.

• In England during 2011, one person was diagnosed with HIV every 90 minutes.

• Almost half of adults newly diagnosed with HIV were diagnosed after the point at which they should have started treatment.

• Rates of infectious syphilis are at their highest since the 1950s.

• Gonorrhoea is becoming more difficult to treat, as it can quickly develop resistance to antibiotics.

• In 2011, 36% of women overall, rising to 49% in black and black British women, having an abortion had had one before.

• In 2011, just over half of women having an abortion had previously had a live or stillbirth, indicating that better support is needed to access contraception following childbirth.

• Estimates from the Crime Survey for England and Wales indicate that there are around 400,000 female victims of sexual offences each year and, of these, around 85,000 are victims of the most serious offences of rape or sexual assault by penetration.

Source: A Framework for Sexual Health Improvement in England, Department of Health 2013

## 9.2 Who is at risk & why?

All those who are sexually active are at risk, however, there are certain groups of the population who are at greater risk, these are:

**Young people**

Most people become sexually active and start forming relationships between the ages of 16 and 24. Young people in these age groups have significantly higher rates of poor sexual health, including STIs and abortions, than older people. There is evidence that reducing the number of sexual partners and avoiding overlapping relationships can reduce the risk of STI acquisition.
Source Sexually transmitted infections in England, 2011, Health Protection Agency

Chlamydia is the most prevalent STI in England and often has no symptoms. To address this, the National Chlamydia Screening Programme (NCSP) aims to test all sexually active under-25s annually, or with each change of partner, as a routine part of primary care and sexual health consultations.
A significant proportion of STI diagnoses among gay and bisexual men continue to be in younger age groups: 34% of genital warts, 24% of gonorrhoea, 22% of genital herpes and chlamydia and 13% of syphilis cases diagnosed in 2011 were in those aged 15–24.
Source: A Framework for Sexual Health Improvement in England, Department of Health 2013

Those aged 16-25 years are more likely to access emergency contraception services provided in pharmacies, the main reason for this is because of unprotected sex. Despite falling rates of teenage pregnancies without support and intervention there is a risk that rates may increase in the future. Educational information and advice, and good access to sexual health services, are vital for young people.

Young people are vulnerable to poor sexual health as described above and in particular those leaving local authority care. As at December 14, there were 676 children and young people looked after looked after in Cumbria registered with Cumbria County Council, of those 187 were aged 16 years and over leaving care.

**Ethnic minorities**

People from Black African and Black Caribbean communities have a higher risk of poor sexual health. Numbers of Black & Minority Ethnic groups are relatively low in Cumbria with just over 17,700 people (3.5% of the total population). Of those, 579 people (0.1%) are of Black/African/Caribbean/Black British ethnicity. In addition to this, 314 people (0.1%) are of 'mixed white and black African' ethnicity. Across Cumbria's districts the greatest proportion of residents of mixed/black/African/Caribbean ethnicity are in South Lakeland (274 residents, 0.3% of the total population) followed by Carlisle (238 residents, 0.2% of the total population).

In the 2011 Census, 315 Cumbrian residents (0.1%) identified their ethnic group as Gypsy or Irish Traveller; similar to the national average. The greatest number of reported gypsy or Irish travellers are in the district of Carlisle (196), and within the district Castle ward had the greatest number (20) while Lyne ward had the greatest proportion (0.5%). It is recognised that numbers of gypsy or Irish travellers are underreported.

**Lesbian, Gay, Bisexual and Transgender (LGBT)**

Currently there is no robust data relating to numbers of the LGBT population in Cumbria. Nationally, it is estimated at around 5 – 7% of the total population, for Cumbria this would equate to 24,895 to 34,853 residents. Research carried out by the LGBT Foundation reports that the lack of a visible scene locally means the LGB&T population is less accessible to public bodies and LGB&T people are isolated in Cumbria. It is important for services to reach out to these groups by providing support and by making services accessible.

**Men having sex with Men (MSM)**

Nationally, gay, bisexual and other men who have sex with men (MSM) account for an estimated 2.6% of the male population. In Cumbria this would equate to 5,285 males aged 16 years and over. This diverse group experiences significant inequalities relating to their health and wellbeing (Source: Bespoke analysis of National Survey of Sexual Attitudes and Lifestyles (Natsal 3) for Public Health England). Gay communities in Cumbria are not particularly visible therefore it is difficult to provide a robust estimate, and according to the LGBT Foundation gay men often travel to other areas such as Manchester and Newcastle.

**Second time arounders**

This refers to people who are now separated or divorced and embarking on new sexual relationships, and in some cases with multiple partners and are considered a group at risk of poor sexual health.

**Prison population**

Prisoners are some of the most vulnerable people in the UK to Blood borne virus infection such as HIV and hepatitis C because:
• A high proportion of prisoners are injecting drug users (IDUs) and the sharing of injecting equipment for drug use poses a very high risk of BBV transmission
• There is some evidence that people who offend are at greater risk of BBV exposure due to heightened sexual risk taking.
• Prisons are an environment where practices which increase the risk of BBV transmission (for example sharing injecting equipment, unprotected sex and tattooing) continue to take place.
Source: Tackling Blood-Borne Viruses in Prisons, Department of Health 2011

HMP Haverigg in the district of Barrow-in-Furness is the only prison in Cumbria. There are approximately 650 inmates/prisoners. In 2013/14 there were 205 people released from Haverigg prison.

**Substance misuse**

Substance misuse can be directly linked to a range of health issues including sexually transmitted infection, both drugs and alcohol misuse pose a serious risk to sexual health for all ages and in particular young people. For further details of these groups refer to sections 4 and 5.

## 9.3 What is the level of need and gaps?

**Sexually Transmitted Infection (STI) testing rates**

The national STI testing rate figure available covers tests for syphilis, HIV, Neisseria Gonorrhoea and chlamydia (in those aged 25 and over) among people accessing sexual health clinics. The STI testing rate in Cumbria is below the national average at 11,100 per 100,000 population compared to 15,366 in England. STI testing rates have been well below the national average between 2012 – 2014. Testing rates are increasing in all districts despite this they remain below England. The proportion of STI testing positivity (exc Chlamydia aged <25) in Cumbria is also below the national average at 4.4% of those aged 15-64 years accessing GUM services compared to 5.4% in England.

Throughout 2013-14, a total number of 1,971 patients were STI screened in GP practices across Cumbria (Tier 1 = 1,432; Tier 2 = 539) compared to 34,545 in 2014 in GUM clinics.

**Rate of new STIs**

In 2014, the number of new STI diagnoses among people accessing GUM services in Cumbria is lower than the national average at 496 per 100,000 compared to 797 in England. Rates are below the national average in all districts, however, they are increasing.

**Chlamydia**

Chlamydia is the most commonly diagnosed sexually transmitted infection. It causes avoidable sexual and reproductive ill-health, including symptomatic acute infections and complications such as pelvic inflammatory disease (PID), ectopic pregnancy and tubal-factor infertility. The chlamydia detection rate amongst under 25 year olds is a measure of chlamydia control activities.

Public Health England recommends that local authorities should be working towards achieving a detection rate of at least 2,300 per 100,000 population. Cumbria currently has a detection rate of 1,707 per 100,000 aged 15-24 years. All districts except Carlisle have a detection rate below 2,300 per 100,000. Source: PHOF

Figure 17: Chlamydia Detection Rates in Cumbria (2014)

| **Area** | **Detection rate per 100,000 15-24 year olds** |
|---|---|
| England | 2,012 |
| North West | 2,288 |
| Cumbria | 1,707 |
| Allerdale | 1,507 |
| Barrow-in-Furness | 1,469 |
| Carlisle | 2,511 |
| Copeland | 1,366 |
| Eden | 1,776 |
| South Lakeland | 1,264 |

**Syphilis**

Syphilis is an important public health issue in men who have sex with men (MSM) among whom incidence has increased over the past decade. Syphilis is primarily diagnosed in GUM clinics. Numbers of syphilis diagnoses are low in Cumbria but have increased from 4 to 12 between 2013 to 2014, a rate of 2.4 per 100,000 which is below the England average of 7.8.

**Gonorrhoea**

Gonorrhoea is used as a marker for rates of unsafe sexual activity. The majority of cases are diagnosed in GUM settings, and consequently the number of cases may be a measure of access to STI treatment. Infections with gonorrhoea are also more likely than chlamydia to result in symptoms. Diagnosis rates in Cumbria are well below the national average at 23.9 per 100,000 compared to 63.3 in England.

Recent increases in rates of both syphilis and gonorrhoea is predominantly in homosexual men aged 25-34 years, similar to the national picture.

**HIV incidence**

In Cumbria in 2013 (as in 2012), there were more cases infected via MSM (7 individuals; 70%) than through heterosexual sex (two individuals; 20%). Proportionately, Cumbria had the highest recorded percentage of AIDS cases (30%; three out of 10 cases), while nearly three quarters of those with HIV living in Merseyside (73%) were without asymptomatic. Source: HIV- North West report 2014

**People presenting with HIV at a late stage of infection**

The late diagnosis indicator is essential to evaluate and promote public health and prevention efforts to tackle the impact of HIV infection. Over half of patients newly diagnosed in the UK are diagnosed late and 90% of deaths among HIV positive individuals within 1 year of diagnosis are among those diagnosed late.

51.5% of adults presenting with HIV do so at a late stage in Cumbria compared to 48.3% in England. HIV testing uptake is below national rates, with 68.2% uptake in Cumbria compared to 77.5% in England. Source: PHOF

**Teenage pregnancy**

Most teenage pregnancies are unplanned. In Cumbria the rate of under 18 conceptions is declining in line with the national trend. In 2013 the rate for Cumbria was 20.2 per 1,000 15-17 year olds compared to 24.3 per 1,000 in England. All districts show a rate of under 18 conception in 2013 similar to England except Eden and South Lakeland where the rate is significantly lower than England. Source: PHOF

**Abortions**

The earlier abortions are performed the lower the risk of complications. Prompt access to abortion, enabling provision earlier in pregnancy, is also cost-effective and an indicator of service quality. Abortions under 10 weeks in Cumbria is significantly lower than England with the proportion of NHS-funded abortions below the national average at 72.1% compared to 79.4% for England. A significantly smaller proportion (22.9%) in Cumbria aged under 25 have repeated abortions compared to England (27%). Source: PHOF

**Contraception method provided at contraceptive clinics**

First contacts with NHS community contraceptive clinics in Cumbria (6,300) during 2012/13 can be broken down into type of contraceptive, 40% were long acting reversible contraceptives (LARC) and 53% were user dependent methods. Compared to 52% and 23% in England respectively. 53% of those first contacts in Cumbria were women under 20 years compared to 27% in England.
Source: HSCIC - NHS Contraceptive Services: England, 2012/13

**GP prescribed LARC**

Cumbria's performance in relation to GP prescribed long acting reversible contraception (LARC) is the best out of all county/unitary authorities in England. The rate in Cumbria is almost double than the national average at 96.3 per 1,000 (of the female population aged 15-44 years) compared to 52.7 for England. 48% of LARC in Cumbrian GPs are IUCD fittings, while 52% are implants. Source: PHOF

**Emergency Hormonal Contraception (EHC)**

Hormonal contraception is the most common form of emergency contraceptive. The dispensing of EHC in the community has declined nationally since 1997/8 and in 2012/13 230,000 items were dispensed nationally. Source: HSCIC - NHS Contraceptive Services: England, 2012/13

Of the 2,304 registered uses of EHC at pharmacies in Cumbria during 2013/14 the majority were aged 16-25 years. The main reason for the use of the service is due to 'unprotected sex' which accounts for 53%. There are differences for using the service depending on age. There are greater numbers of those aged 17 years using the service because of a failed condom; there are greater numbers of those aged 19 years using the service because of missed or incorrectly used pill or patch; and there are greater numbers of those aged 20 years using the service because of unprotected sex. Greater numbers of those in their early 30s tend to use the service because of a failed condom.

## 9.4 Current Services and Assets including projections

- GPs
- Pharmacies
- Integrated sexual health clinics - Four hubs: Barrow, Kendal, Carlisle and Workington
- Additional clinics:
    - Inspira - Advice Centre Workington
    - The Senhouse Centre Whitehaven
    - Flatts Walk Health Centre, Whitehaven
    - Penrith Hospital
    - Newton Rigg College - Penrith,
    - The Lakes School, WIndermere
    - Ambleside Health Centre
    - Windermere Health Centre
    - Furness College
    - 6th form college, Barrow

Sexual Healthline Cumbria

Currently free condoms are not available to patients via GP practices unless provided by the practice themselves.

## 9.5 Evidence of what works

Some key principles of best practice in sexual health commissioning, have been highlighted by Department of Health. These are:

• prioritising the prevention of poor sexual health;

• strong leadership and joined-up working;

• focusing on outcomes; addressing the wider determinants of sexual health;

• commissioning high-quality services, with clarity about accountability;

• meeting the needs of more vulnerable groups; and

• good-quality intelligence about services and outcomes for monitoring purposes.

Source: A Framework for Sexual Health Improvement in England, DOH 2013

Other guidance also provides recommendations for consideration around the issues for local determination and the quality of services and outcomes:

Services which are easy to get to and are accessible in terms of location, opening hours and waiting times mean that people will be more likely to attend – which in turn can reduce the incidence of STIs and unwanted pregnancy, and reduce the public health and other social costs associated with these issues.

Ensuring the correct mix of clinical and other professional staff, working within safe and robust clinical governance protocols, can help to offer better and more accessible services for patients, which are more cost effective for service commissioners.

Source: Commissioning Sexual Health services and interventions, DoH, 2013

## 9.6 User views

A full sexual health needs assessment is being produced (due in 2015) that includes results from a general sexual health survey, sexual health clinic user survey and input from other groups.

Headline responses from the user and general health survey indicate that people find it hardest to speak to family members about sexual health issues.

The most common places people go to for sexual health information is the internet and family doctor. Most people knew where to go for contraception and the service where the least number of people knew where to go was abortion or advice about abortion.

Generally people find it easier to speak to friends or a GP/family doctor but users of the sexual health clinic reported nurses at GUM/sexual health clinic were easiest to speak to about sexual health issues.

The most common important elements of the sexual health service were feeling like I am treated with respect, service is confidential and staff are non-judgmental.

# 10 Mental Wellbeing

It is recognised mental wellbeing is a key element to healthy living for communities in Cumbria with the detail and data around this area to be included in the mental health and wellbeing chapter due for publication in 2017.

# 11 Geographical differences in need

Obesity profiles were completed for all six Cumbria Districts in 2014 and are available here: http://www.cumbriaobservatory.org.uk/health/JSNA/previous/Districts.asp

Alcohol information for districts is available here:

http://fingertips.phe.org.uk/profile/local-alcohol-profiles

Tobacco information for districts is available here:

http://www.tobaccoprofiles.info/

Sexual health information for districts is available here:

http://fingertips.phe.org.uk/profile/sexualhealth/data

## 11.1 Allerdale

588 substance misuse service users came into contact with Unity in 2014/15 (an increase of 102 users from the previous year). 41% use alcohol as their main drug; 40% use heroin. Most users are male and aged between 36-45years. 35% of service users have a child/children living with them.

Alcohol misuse is a serious issue in Allerdale with rates of a range of alcohol related health issues significantly worse than England. These include: alcohol specific hospital admissions for under 18s; hospital admission episodes for alcohol related conditions (both male and female); and alcohol specific mortality in females which has increased recently and is now significantly above the national average at 12.9 per 100,000 compared to 7.5 in England. There are a number of other alcohol related indicators including hospital admissions relating to liver disease; and those linked with mental health i.e. admission episodes for alcohol-related mental and behavioural disorders due to use of alcohol condition, which are all above national levels.

Obesity levels in adults (those aged 16 and over with a BMI equal to or over 30kg/$m^2$) in Allerdale are estimated at 24.8% based on modelled estimates (2013) from the Health Survey for England reported results (2006-2008). This is similar to the CACI Acorn (2014) estimated proportion of obese residents at 23.1%, above the Cumbria and UK average. Within Allerdale, Moss Bay is one of the top five wards with the greatest estimated proportion of residents with BMI greater than 30kg/$m^2$ at 25.7%. Already highlighted as a Ward with high levels of child excess weight, this indicates a clear link between levels of excess weight established in childhood being carried forward into adulthood. Further figures based on the Active People Survey, Sport England (2012/13) indicate that 66.5% of adults in Allerdale are overweight and/or obese (with a BMI in excess of 25kg/$m^2$).

The Integrated Household Survey (IHS) reported that in 2013 the prevalence of smoking among persons aged 18 years and over was 16.2% in Allerdale; this was similar to the national average of 18.4%.

The IHS also reported that the prevalence of smoking among persons aged 18 years and over in routine and manual occupations was 28.3% in Allerdale; again this was similar to the national average of 28.6%.

Based on the socio-economic profile of the district's residents, the ACORN tool estimates that 21.8% of Allerdale's residents currently smoked in 2014; close to the national average of 20.6%.

The ACORN tool also estimates that the highest rates of current smokers amongst Allerdale's wards are likely to be found in: Moss Bay (with an estimated 36.3% of residents being smokers); Moorclose (33.8%); Ewanrigg (33.8%); St Michael's (32.0%); and Flimby (28.4%).

Figure 18: Drug offences in Allerdale for the last 3 financial years

| Type of drugs offence | 2011/12 | 2012/13 | 2013/14 | % change in the last year |
|---|---|---|---|---|
| Drugs (possession) | 394 | 272 | 321 | +18.0 |
| Drugs (trafficking) | 93 | 42 | 75 | +78.6 |
| All drug offences | 487 | 314 | 396 | +26.1 |

## 11.2 Barrow-in-Furness

728 substance misuse service users came into contact with Unity (an increase of 88 users from the previous year). 45% of those use heroin as their main drug; 40% use alcohol.
67% of users are male. Most users are aged between 36-45years. 38% of service users have a child/children living with them.

Alcohol misuse in Barrow-in-Furness is a serious issue with rates of all alcohol related hospital admissions above national levels. In addition to this, rates of alcohol related mortality and mortality from chronic liver disease are also above national levels in the district.

Admission episodes for alcohol-related cardiovascular disease conditions, alcohol-related mental and behavioural admissions and intentional self-poisoning are also above national levels, furthermore, alcohol related unintentional injuries are above national levels.

Adult obesity rates in Barrow are estimated at 26.1% (modelled estimate (2013) based on Health Survey for England reported results (2006-2008)), the highest rate of all Cumbria's districts. CACI Acorn data (2014) also estimate a high proportion of obese residents (24.0%). Within Barrow there are two Wards identified as being within the top five wards in the county for obese adults: Hindpool (26.9%) and Central (26.4%). Both these Wards also have high levels of childhood obesity, indicating that trends established in early years are closely linked to adult obesity. The total proportion of adults classed as overweight and/or obese is estimated to be in the region of 67.0% (based on the Active People Survey, Sport England (2012/13)). Diet is often linked to overweight and obesity issues, and the Active People Survey (2014) highlights Barrow as the district within Cumbria with the lowest rate of people regularly consuming the recommended '5 a day' portion of fruit and vegetables.

The Integrated Household Survey (IHS) reported that in 2013 the prevalence of smoking among persons aged 18 years and over was 23.4% in Barrow-In-Furness; this was similar to the national average of 18.4%.

The HIS also reported that the prevalence of smoking among persons aged 18 years and over in routine and manual occupations was 21.6% in Barrow-In-Furness; again this was similar to the national average of 28.6%.

Based on the socio-economic profile of the district's residents, the ACORN tool estimates that 24.7% of Barrow-In-Furness's residents currently smoked in 2014; close to the national average of 20.6%.

The ACORN tool also estimates that the highest rates of current smokers amongst Barrow-In-Furness's wards are likely to be found in: Central (with an estimated 34.2% of residents being smokers); Hindpool (33.7%); Risedale (31.4%); Ormsgill (30.4%); and Barrow Island (30.2%).

Figure 19: Drug offences in Barrow for the last 3 financial years

| **Type of drugs offence** | **2011/12** | **2012/13** | **2013/14** | **% change in the last year** |
|---|---|---|---|---|
| Drugs (possession) | 150 | 170 | 172 | +1.2 |
| Drugs (trafficking) | 37 | 36 | 64 | +77.8 |
| All drug offences | 187 | 206 | 236 | +14.6 |

## 11.3 Carlisle

849 service users came into contact with Unity (an increase of 176 users from the previous year). 50% of those use heroin as their main drug: 38% use alcohol. 67% of users are male. Most users are aged between 36-45 years. 31% of service users have a child/children living with them.

Alcohol misuse is a serious issue in Carlisle with rates of almost ALL alcohol related hospital admissions above national levels rates. A range of alcohol related health issues are significantly worse than England, these include: admission episodes for alcohol-related cardiovascular disease conditions; Admission episodes for alcohol-related alcoholic liver disease condition. Other indicators which are worse than the national average include: admission episodes for alcohol-related malignant neoplasm conditions; alcohol-related mental and behavioural disorders; and intentional self-poisoning.

Obesity amongst adults in Carlisle is estimated by CACI Acorn (2014) at 23.1%. Modelled estimates (2013) based on Health Survey for England reported results (2006-2008) estimate that 24.3% of Carlisle's adult population are obese, slightly above the average for Cumbria and England. Morton is one of the top five wards in the county with the greatest estimated proportion of residents with BMI >30 at 25.7%. Furthermore, the Active People Survey, Sport England (2012/13) estimates that 68.4% of adults in Carlisle are overweight and/or obese. The Active People Survey (2014) identified that consumption of fruit and vegetables is below the national average, and less than the recommended 5 portions per day, something that could have an impact on obesity levels.

The Integrated Household Survey (IHS) reported that in 2013 the prevalence of smoking among persons aged 18 years and over was 20.7% in Carlisle; this was similar to the national average of 18.4%.

The HIS also reported that the prevalence of smoking among persons aged 18 years and over in routine and manual occupations was 28.8% in Carlisle; again this was similar to the national average of 28.6%.

Based on the socio-economic profile of the district's residents, the ACORN tool estimates that 22.5% of Carlisle's residents currently smoked in 2014; close to the national average of 20.6%.

The ACORN tool also estimates that the highest rates of current smokers amongst Carlisle's wards are likely to be found in: Upperby (with an estimated 32.4% of residents being smokers); Botcherby (31.6%); Castle (31.2%); Currock (30.8%); and Denton Holme (29.9%).

Figure 20: Drug offences in Carlisle for the last 3 financial years

| Type of drugs offence | 2011/12 | 2012/13 | 2013/14 | % change in the last year |
|---|---|---|---|---|
| Drugs (possession) | 417 | 399 | 329 | -17.5 |
| Drugs (trafficking) | 60 | 67 | 74 | +10.4 |
| All drug offences | 477 | 466 | 403 | -13.5 |

## 11.4 Copeland

432 substance misuse service users came into contact with Unity (an increase of 105 users from the previous year). 50% of clients use alcohol as their main drug; 33% use heroin. 63% of users are male. Most users are aged between 36-45 years. 41% of service users have a child/children living with them.

Alcohol misuse is a serious issue in Copeland with rates of alcohol-specific hospital admission for under 18s significantly worse than the rest of England. Other indicators which are worse than England include: alcohol-specific hospital admissions and admission episodes for alcohol-related conditions. Admission episodes for alcohol-related cardiovascular disease conditions are also much worse in the district than the rest of England, in addition, so are admission episodes for alcohol-related mental and behavioural disorders; and alcohol-related malignant neoplasm conditions.

Adult obesity levels in Copeland are estimated to be in the region of 25.7% from modelled estimates (2013) based on Health Survey for England reported results (2006-2008), higher than the Cumbria and England average. CACI Acorn (2014) makes a slightly lower estimate of obesity levels at 23.2%. However, the Active People Survey, Sport England (2012/13) estimates that 75.9% of all adults in Copeland are overweight or obese, ranking Copeland with the highest levels of excess weight of any other lower tier local authority in both the North West region and in England.

The Integrated Household Survey (IHS) reported that in 2013 the prevalence of smoking among persons aged 18 years and over was 20.1% in Copeland; this was similar to the national average of 18.4%.

The IHS also reported that the prevalence of smoking among persons aged 18 years and over in routine and manual occupations was 25.8% in Copeland; again this was similar to the national average of 28.6%.

Based on the socio-economic profile of the district's residents, the ACORN tool estimates that 23% of Copeland's residents currently smoked in 2014; close to the national average of 20.6%.

The ACORN tool also estimates that the highest rates of current smokers amongst Copeland's wards are likely to be found in: Sandwith (with an estimated 32.8% of residents being smokers); Mirehouse (32.7%); Cleator Moor South (30.5%); Distington (27.8%); and Newtown (27.1%).

Figure 21: Drug offences in Copeland for the last 3 financial years

| Type of drugs offence | 2011/12 | 2012/13 | 2013/14 | % change in the last year |
|---|---|---|---|---|
| Drugs (possession) | 219 | 168 | 146 | -13.1 |
| Drugs (trafficking) | 22 | 39 | 42 | +7.7 |
| All drug offences | 241 | 207 | 188 | -9.2 |

## 11.5 Eden

234 substance misuse service users came into contact with Unity (an increase of 22 users from the previous year). 53% of clients use alcohol as their main drug; 30% use heroin. 59% of users are male. Most users are aged between 26-35 years. 29% of service users have a child/children living with them.

Alcohol misuse in Eden isn't such a serious issue as in other districts in Cumbria, however, rates of admission episodes for alcohol-related cardiovascular disease conditions (all persons) are above national levels at 1,171 per 100,000 compared to 1,049 for England, this indicator is a particular issue in males. Rates of admission episodes for alcohol-related malignant neoplasm conditions narrow (all persons) are also above national levels at 184.9 per 100,000 compared to 150.7 for England.

Adult obesity rates for Eden are below the average for England and Cumbria at 23.8% according to modelled estimates (2013) based on Health Survey for England reported results (2006-2008). CACI Acorn 2014 estimates the proportion of obese residents slightly lower at 21.8%. However, within Eden, Penrith Pategill ward is one of the top five wards in the county with the greatest estimated proportion of residents with BMI more than 30kg/$m^2$ at 26.6%.
The percentage of adults classed as overweight and/or obese in Eden is still high at 68.76% according to the Active People Survey, Sport England (2012/13), significantly above the England average.

The Integrated Household Survey (IHS) reported that in 2013 the prevalence of smoking among persons aged 18 years and over was 15.2% in Eden; this was similar to the national average of 18.4%.

The IHS also reported that the prevalence of smoking among persons aged 18 years and over in routine and manual occupations was 35.8% in Eden; again this was similar to the national average of 28.6%.

Based on the socio-economic profile of the district's residents, the ACORN tool estimates that 15.8% of Eden's residents currently smoked in 2014; close to the national average of 20.6%.

The ACORN tool also estimates that the highest rates of current smokers amongst Eden's wards are likely to be found in: Penrith Pategill (with an estimated 29.8% of residents being smokers); Penrith West (26.4%); Penrith South (22.4%); Penrith East (20.8%); and Appleby (Appleby) (20.6%).

Figure 22: Drug offences in Eden for the last 3 financial years

| Type of drugs offence | 2011/12 | 2012/13 | 2013/14 | % change in the last year |
|---|---|---|---|---|
| Drugs (possession) | 176 | 119 | 118 | -0.8 |
| Drugs (trafficking) | 28 | 31 | 18 | -41.9 |
| All drug offences | 204 | 150 | 136 | -9.3 |

## 11.6 South Lakeland

409 service users came into contact with Unity (an increase of 72 users from the previous year). 31% use heroin as their main drug; 53% use alcohol (increase). 65% of users are male. Most users are aged between 36-45 years. 27% of service users have a child/children living with them.

Rates of alcohol-specific hospital admissions for under 18s are above national levels and are almost double at 78.8 per 100,000 compared to 40.1 for England. Admission episodes for alcohol-related conditions are also above national levels and in particular in females. Rates of admission episodes for alcohol-related malignant neoplasm conditions are above national levels and, again, are a particular issue in females. Rates of admission episodes for alcohol-related mental and behavioural disorders; and admission episodes for alcohol-related intentional self-poisoning are also above national levels in the district.

Adult obesity levels in South Lakeland are also the lowest in Cumbria at 20.5% according to modelled estimates (2013) based on Health Survey for England reported results (2006-2008). These rates are also lower than the average for England and Cumbria. CACI Acorn (2014) data also estimates the proportion of obesity in adults at below the Cumbria average at 21.8% but above the UK average. Information from the Active People Survey, Sport England (2012/13) also shows that estimated levels of excess weight and/or obesity in South Lakeland are the lowest in the county, however, estimated levels are still high at 65.8%.

The Integrated Household Survey (IHS) reported that in 2013 the prevalence of smoking among persons aged 18 years and over was 14.1% in South Lakeland; this was better than the national average of 18.4%.

The HIS also reported that the prevalence of smoking among persons aged 18 years and over in routine and manual occupations was 29.2% in South Lakeland; this was similar to the national average of 28.6%.

Based on the socio-economic profile of the district's residents, the ACORN tool estimates that 16.5% of South Lakeland's residents currently smoked in 2014; close to the national average of 20.6%.

The ACORN tool also estimates that the highest rates of current smokers amongst South Lakeland's wards are likely to be found in: Kendal Kirkland (with an estimated 28.7% of residents being smokers); Kendal Underley (26.6%); Ulverston East (26.6%); Kendal Far Cross (26%); Ulverston Town (25.1%).

Figure 23: Drug offences in South Lakeland for the last 3 financial years

| Type of drugs offence | 2011/12 | 2012/13 | 2013/14 | % change in the last year |
|---|---|---|---|---|
| Drugs (possession) | 186 | 149 | 148 | -0.7 |
| Drugs (trafficking) | 33 | 35 | 21 | -40.0 |
| All drug offences | 219 | 184 | 169 | -8.2 |

## 12 Key Contacts

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## 13 Links to data sources

Where possible links have been included within the document, a significant amount of information can be found on the Public Health Outcomes Framework (PHOF) http://www.phoutcomes.info/

Further information regarding participation in Physical Activity can be found by visiting http://www.sportengland.org/research/who-plays-sport/active-people-interactive/