Westmorland & Furness Council

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Director of Public Health Annual Report 2024

Building better health for all

Foreword

This Annual Report is the first Director of Public Health Annual Report for Westmorland and Furness. As the first Annual Report for a new unitary local authority area, it aims to set the scene and provide an overview of health and wellbeing in Westmorland and Furness.

Whilst the overall health and wellbeing of people living in Westmorland and Furness is good, when we look at the health of different neighbourhoods and communities in Westmorland and Furness we see significant differences in people's experiences of health and wellbeing. People living in our most deprived areas are spending more of their lives in poorer health and sadly these health inequalities are widening.

Our health and wellbeing is shaped by our life experiences and the places in which we are born, work, live and age. We need to make urgent improvements in these building blocks of health and wellbeing if we are to improve our health and wellbeing. To address health inequalities we must seek to make improvements across Westmorland and Furness but give proportionately greater focus to our places and communities which face the poorest outcomes.

Our rural and coastal landscape presents both benefits and challenges for health and wellbeing. Access to green and blue space has both direct and indirect benefits for health and wellbeing, including reduced exposure to air pollution, and supporting physical activity. However, the 2021 and 2023 Chief Medical Officer Annual Reports both highlighted the significant health challenges faced by rural and coastal communities.

Westmorland and Furness, in common with other rural and coastal areas, has an ageing population. The proportion of the population over age 65 is increasing significantly, and people are spending a greater number of years of life in poor health. Many of the diseases that cause this ill health are associated with common risk factors and can be prevented.

These trends mean we cannot delay in taking concerted action to improve health and wellbeing. Our approach to preventing ill health must reflect all the economic, societal and environmental factors which impact on health and wellbeing. A much stronger focus on prevention at all stages of life is needed to improve quality of life and delay onset of disease. With more people living with multi-morbidity and frailty, we also need to support and empower individuals and communities to ensure people can live with independence in the community for as long as possible.

This report primarily focuses on quantitative data, but importantly it also draws on data from local research and community engagement to describe residents' experiences of, and priorities for, health and wellbeing. Actively listening to, empowering and working alongside our residents and communities needs to be at the centre of all our work to improve health and wellbeing.

Sincere thanks must go to all members of the Public Health Team who have been involved in producing the report, and in particular to Dr Eleesia Kilgallon, Specialty Registrar in Public Health, who has worked tirelessly to analyse the wealth of data available and present it with precision and clarity. In addition Meinir Jones and Vicky Hepworth-Putt have played significant roles in producing this final report which you are now reading. Thank you to you all.

Katrina Stephens
Director of Public Health - Westmorland and Furness

I am pleased to introduce the Public Health Annual Report for Westmorland and Furness Council. It offers a timely opportunity to reflect on the health and wellbeing of our communities, celebrate our achievements, and consider the challenges we continue to face.

The report sets out a comprehensive overview of public health across our area – from the enduring impact of the COVID-19 pandemic to the growing pressures linked to the cost-of-living crisis. It highlights the stark inequalities that persist in health outcomes and access to services and underlines the urgent need for continued partnership working to improve lives across our towns, villages and rural communities.

Despite these challenges, there is much to be proud of. We have strong partnerships with the NHS, voluntary and community sector, schools, and other local organisations, all of whom have played a vital role in improving health and reducing inequalities. Together, we are making progress in supporting mental wellbeing, promoting healthy lifestyles, tackling substance misuse, and protecting people through prevention and early intervention.

Our public health team continues to demonstrate its commitment, expertise and compassion in all that it does – working not just to reduce illness, but to address the wider determinants of health, such as housing, education, employment and the environment. This report reflects their tireless efforts and the difference they make every day to residents' lives.

As we look to the future, we remain committed to building a fairer, healthier Westmorland and Furness – one where everyone can thrive. I would like to thank all those who have contributed to this shared ambition, and I dedicate this report to you.

Councillor Patricia Bell
Cabinet Member for Adult Care and Health

Executive Summary

1. Whilst the overall health and wellbeing of people living in Westmorland and Furness is good, across Westmorland and Furness, lives are being cut short. People living in our most deprived areas are spending more of their lives in poorer health. Many of the diseases that cause ill health are associated with common risk factors and can be prevented.
2. Our health and wellbeing is shaped by our life experiences and the places in which we are born, work, live and age. These are the building blocks of health and wellbeing and impact our health throughout the life course, beginning from before we are born.
3. Our approach to preventing ill health must reflect our knowledge of these causes. Prevention at all stages of life can delay disease onset and improve quality of life.
4. Actions to influence good health and wellbeing in the early years are key to reducing our risk of poor physical and mental health in adulthood, because our ability to adapt to changes in our environment reduces over time.
5. Our population is ageing, and more people are living with multimorbidity and frailty. We need to plan for this to support our residents to live with independence and maximise their quality of life.
6. Our rural and coastal communities are facing specific challenges to their health and wellbeing. To improve health and wellbeing, we need to work collaboratively to place health at the centre of all of our policy and service areas.
7. Health inequalities are widening, and more people are experiencing multiple disadvantages to their health. We need to improve the health and wellbeing of all our residents, with proportionately greater focus in our places and communities which have the greatest needs.

Contents

1. Introduction

Our health encompasses our physical, mental and social wellbeing and is one of our greatest assets. Over the past century, there have been revolutionary advances in our health across society[1]. In 1924, life expectancy in England was 56.2 years for men and 60.1 years for women; today this is 79.3 years for men and 83.2 years for women[2]. However, over the past decade, these national gains in life expectancy have begun to stall and the number of years people can expect to live in poorer health has risen[2].

Our health is intrinsically linked to our life experiences and the places in which we are born, work, live and age[3]. These form the building blocks which shape our health and wellbeing and are thought to account for around half of the overall health of the population[4]. When these building blocks are missing or unstable, our opportunities and outcomes are adversely impacted, and we spend more of our lives experiencing poorer health[5].

The conditions in which we are born, live, work and grow (the strength of the building blocks of health and wellbeing) are not equal across the population, leading to health inequalities: differences in health across the population and between different groups in society that are systematic, unfair and avoidable[6]. Inequalities can also impact on the quality and experience of the care people receive[6]. Nationally, health inequalities are widening[6]. This has been starkly highlighted by the major challenges faced by society in recent years, including the COVID-19 pandemic and significant rises in the cost of living[7].

This report aims to provide a summary of our health in Westmorland and Furness, with a focus on the impact of inequalities. It begins by describing the overall health state of our population through analysing and summarising existing national and local data. Chapter three of this report examines the key drivers of ill health across the life course and the role of prevention in improving outcomes for our residents. Finally, the report considers the challenges to our future health across each stage of the life course, highlights key case studies of best practice to tackle these challenges and presents a series of recommendations to build better health for all in Westmorland and Furness.

References

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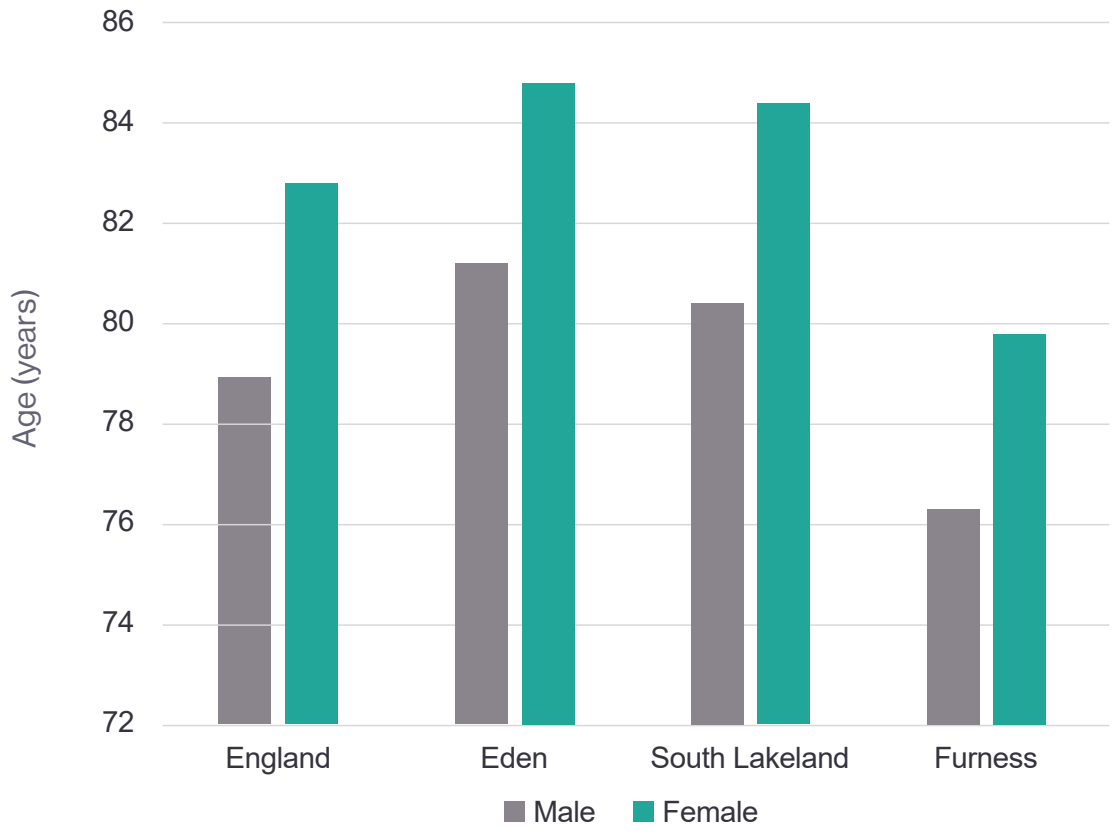
2. Understanding health inequalities in Westmorland and Furness

Whilst the overall health and wellbeing of people living in Westmorland and Furness is good, across Westmorland and Furness lives are being cut short[1]. Life expectancy is a measure of how long, on average, a baby born today is expected to live if they experienced the current mortality rates throughout their lifetime. It is a key indicator of the overall health of our population and can be used to assess changes in our health over time and across different geographical areas. It provides information on the length of life we live, but not the quality of life we experience.

2.1 Life expectancy isn't equal across Westmorland and Furness

Life expectancy for males is 76.3 years in Furness, 80.4 years in South Lakeland and 81.2 years in Eden[1]. For females, life expectancy is 79.8 years in Furness, 84.4 years in South Lakeland and 84.8 years in Eden[1].

Figure 2.1: Graph of life expectancy at birth in Westmorland and Furness compared to England, 2020-2022[1].



2.2 Whilst life expectancy in Eden and South Lakeland remains better than the national average, the gains in life expectancy we have previously seen are now beginning to stall

Life expectancy was lower for both males and females in the years 2020 to 2022, compared to 2017 to 2019, in all three localities[1]. This reflects changes seen nationally following higher than average mortality rates experienced across society during the COVID-19 pandemic that have worsened pre-existing inequalities in health outcomes across our population[2].

Figure 2.2: Changes in life expectancy at birth for males in Westmorland and Furness between 2001-2003 and 2020-2022[1].

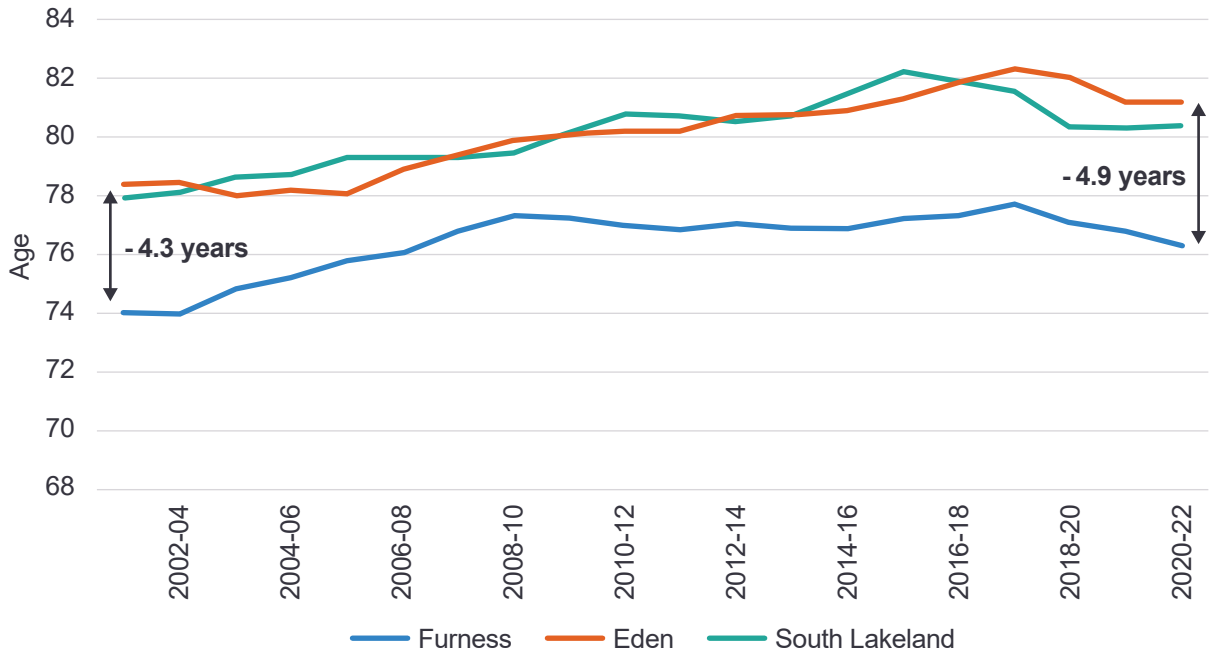
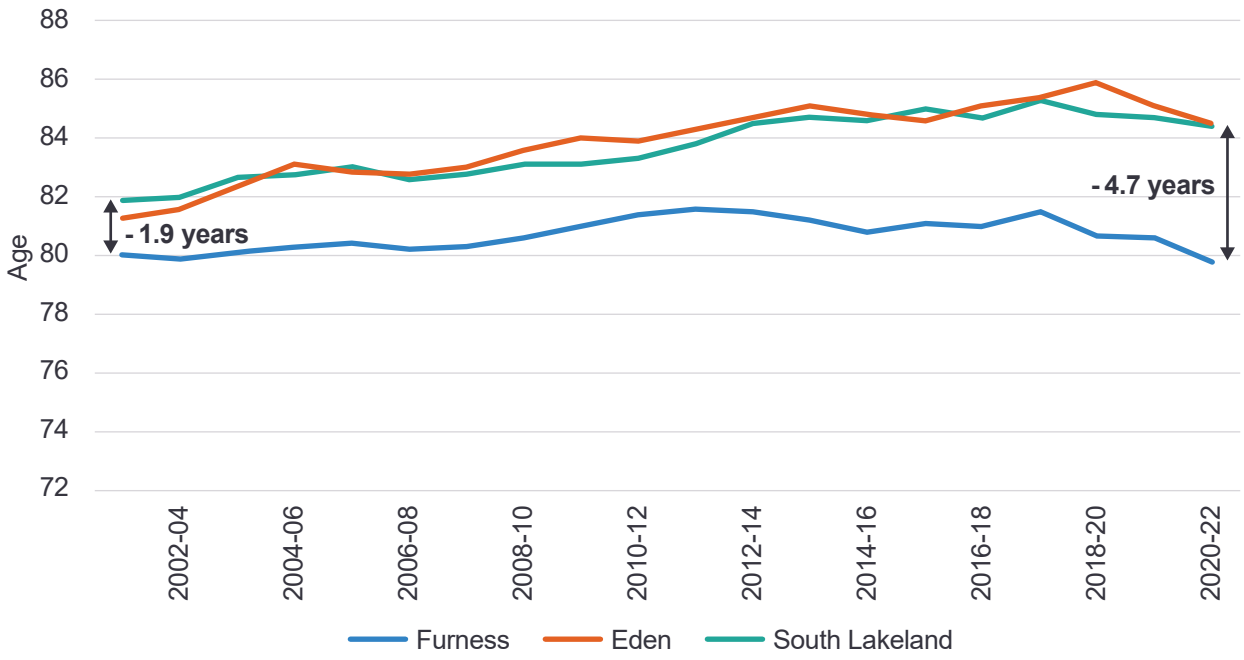


Figure 2.3: Changes in life expectancy at birth for females in Westmorland and Furness between 2001-2003 and 2020-2022[1].



2.3 Inequalities in life expectancy across Westmorland and Furness are widening, particularly for women

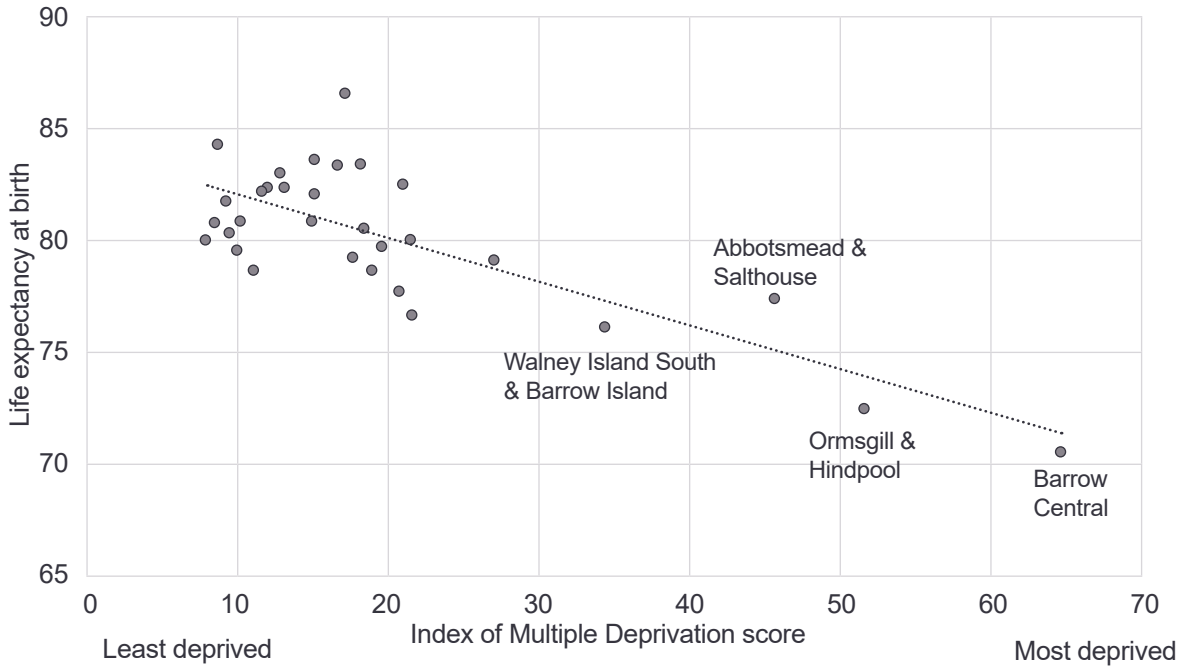
Female life expectancy in Furness is now the lowest it has been since 2003[1]. The gap in life expectancy for women between Furness and South Lakeland was 1.9 years in 2001-03, but today has increased to 4.7 years[1].

The gap in life expectancy in Furness compared to England is also widening[1]. Female life expectancy has fallen by 21 months over the past decade, which is the second largest fall in life expectancy for females of all local areas in England[1]. Women in Furness currently have the same life expectancy as the average female life expectancy in England in 1997-99: a lag of 23 years[1]. For men, the lag in life expectancy between Furness and England is 16 years[1].

2.4 In our most deprived areas, people are dying at younger ages

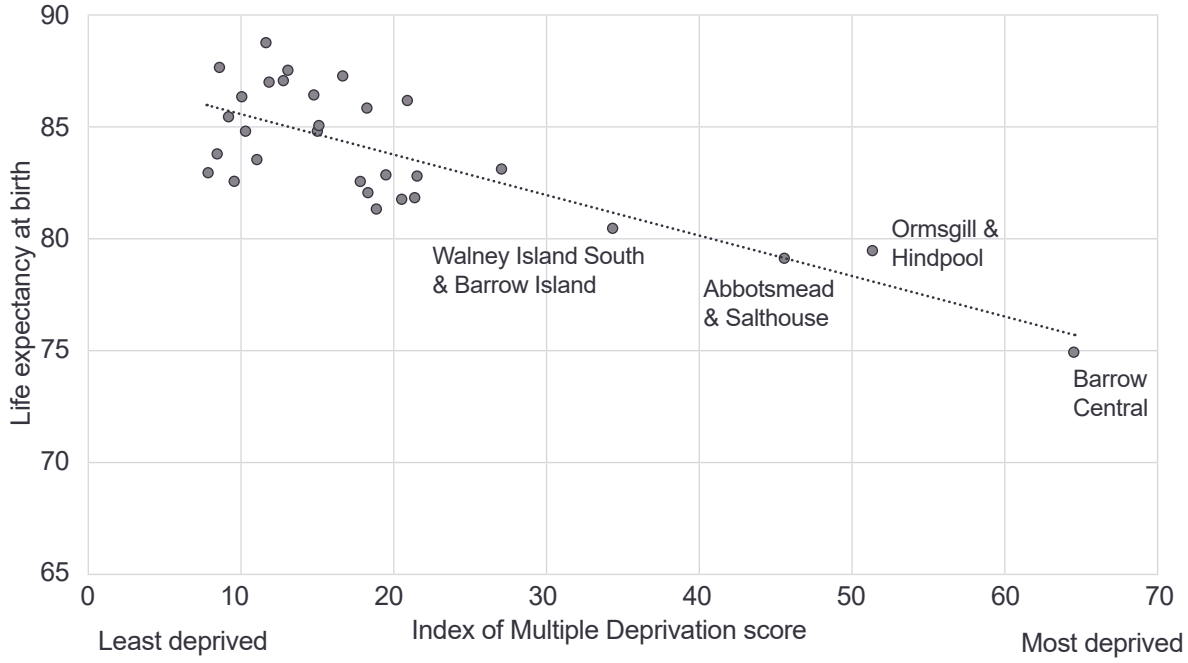
Life expectancy for men in Barrow Central is 16.1 years less than in Hawkshead and Cartmel Fell. Life expectancy for women in Barrow Central is 13.8 years less than in Windermere South and Staveley[1].

Figure 2.4: Life expectancy at birth for males by middle-layer super output area (MSOA) by Index of Multiple Deprivation (IMD) score in Westmorland and Furness, 2016-2020[1].



For men in Cumbria, the leading causes of the gap in life expectancy between our most and least deprived areas are deaths from injuries, poisoning (including drug-related deaths) and suicide, followed by circulatory disease (including heart disease and strokes), and cancer[3]. These causes accounted for 375 excess deaths in 2020-21[3]. If our most deprived areas had the same mortality rates as our least deprived areas we would have seen 375 fewer deaths in 2020-21[3].

Figure 2.5: Life expectancy at birth for females by middle-layer super output area (MSOA) by Index of Multiple Deprivation (IMD) score in Westmorland and Furness, 2016-2020[1].



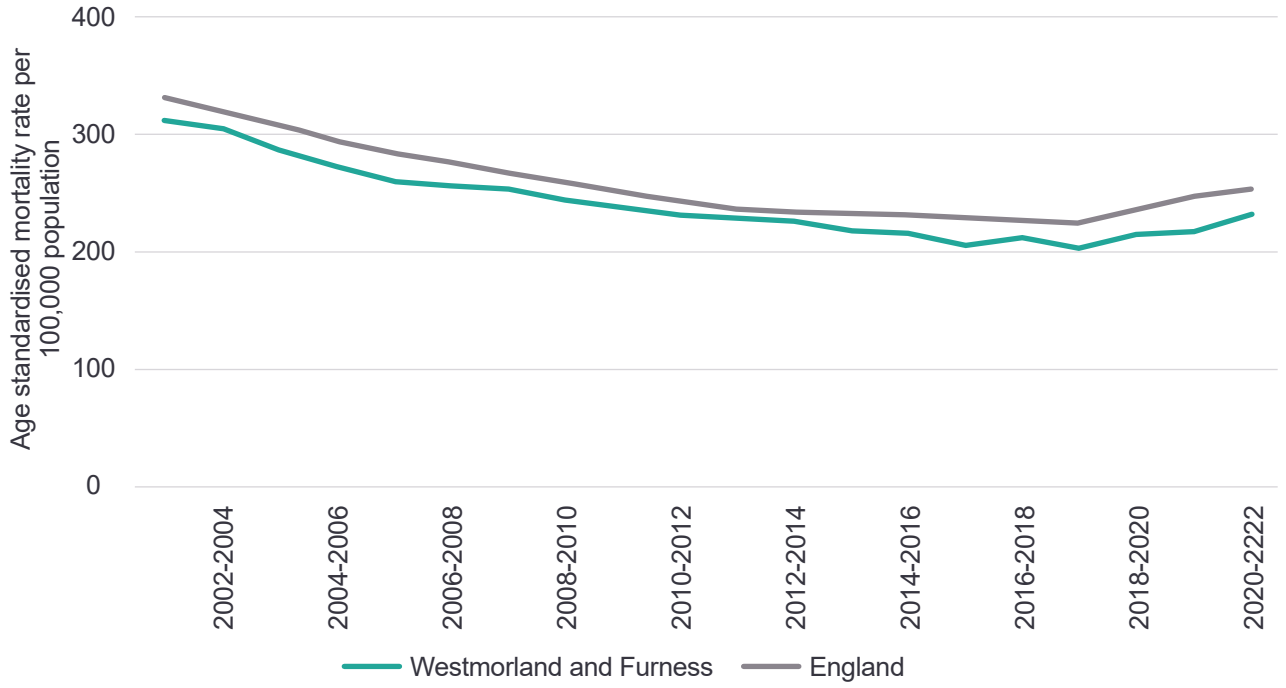
For women in Cumbria, the leading causes of the gap in life expectancy between our most and least deprived areas are respiratory disease (including flu, pneumonia and chronic conditions such as COPD, chronic obstructive pulmonary disease); deaths from injury, poisoning and suicide and cancer[3]. These causes accounted for 217 excess deaths in 2020-21[3]. If our most deprived areas had the same mortality rates as our least deprived areas, we would have seen 217 fewer deaths in 2020-21[3].

2.5 The rate of avoidable deaths in Westmorland and Furness has increased back to 2010-2012 levels

Avoidable deaths refers to deaths that are considered to be either preventable or treatable. Preventable deaths are deaths that could be avoided through public health and primary prevention interventions including vaccine-preventable diseases, some cancers, heart disease and strokes and chronic respiratory diseases such as COPD. Treatable deaths are deaths that can be mainly avoided through healthcare interventions, including secondary prevention and treatment of disease.

As seen in England, the rate of avoidable deaths in Westmorland and Furness has increased following the COVID-19 pandemic[4]. In 2020-2022, there were 1,681 deaths in Westmorland and Furness that were considered avoidable[4]. Just over 2 out of every 3 avoidable deaths were attributed to conditions considered to be preventable, whereas around 1 out of every 3 avoidable deaths were attributed to conditions considered to be treatable[4].

Figure 2.6: Age-standardised rate of avoidable deaths per 100,000 population in Westmorland and Furness compared to England, 2001-2003 to 2020-2022[4].



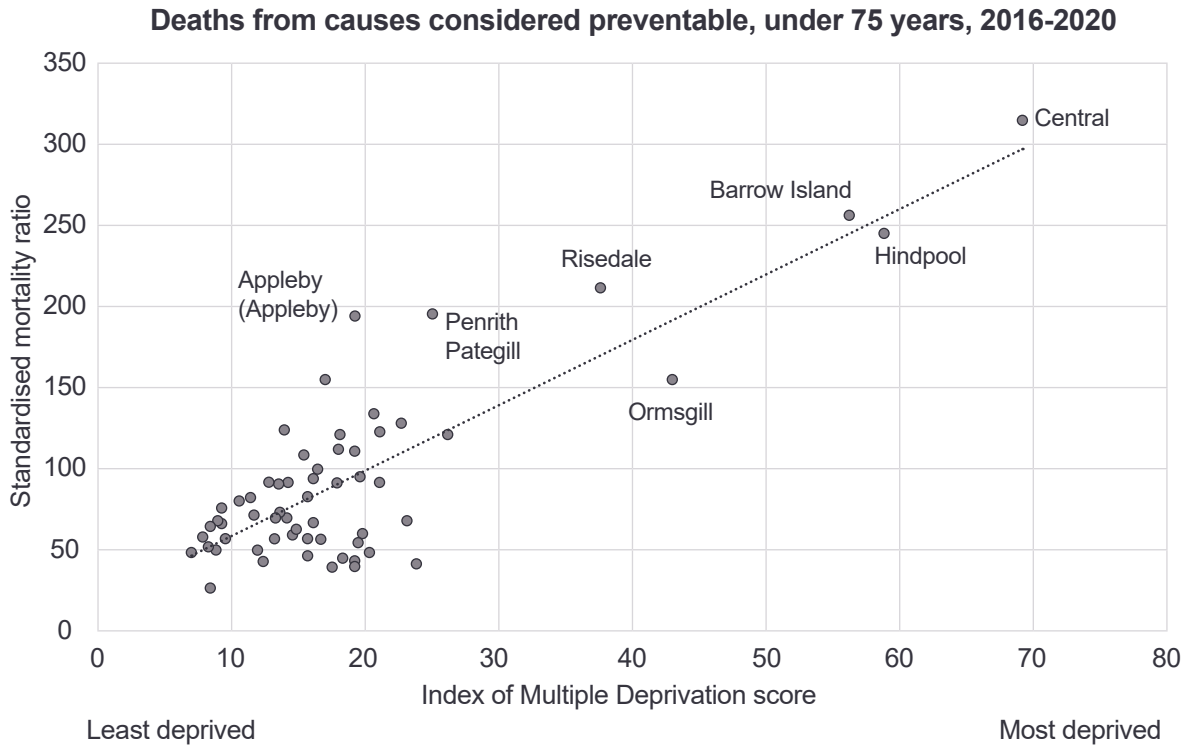
2.6 In our most deprived areas, more people are dying early from preventable causes

Preventable deaths can be measured by the Standardised Mortality Ratio (SMR), which examines the number of deaths in an area (pre-2023 electoral wards in Westmorland and Furness in this case[i]) to establish if this is low or high relative to the number of deaths in the broader population of England, accounting for the different age distributions of the population.

Many areas in Westmorland and Furness have a lower risk of early preventable death than the national average, but this is not the case for many of our wards which experience high levels of deprivation[1]. In 2016-2020, the risk of preventable death in people aged under 75 was over 3 times above the national average in Central ward in Furness, compared to half the national average in Penrith Carleton[1].

[i] This reflects the geographical footprint on which data is currently available. Future data releases will be based on the current Westmorland and Furness electoral wards.

Figure 2.7: Standardised mortality ratio of deaths from causes considered preventable in under 75 year olds by Index of Multiple Deprivation (IMD) score for wards in Westmorland and Furness, 2016-2020[1].



2.7 People in Cumbria are spending more of their lives in poorer health

Disability free life expectancy is a measure of how long, on average, a baby born today is expected to live free of illness that limits daily activities if they experienced the current health and mortality rates throughout their lifetime. It is a key indicator of our quality of life we experience.

In 2018-2020, disability free life expectancy for men in Cumbria was 61 years; a fall of 1.1 years from 2014-16[1]. In 2018-2020, disability free life expectancy for women in Cumbria was 58.9 years; a fall of 5.7 years from 2014-16[1].

Figure 2.8: Disability free life expectancy for males in Cumbria compared to England, 2014-2016 to 2018-2020[1].

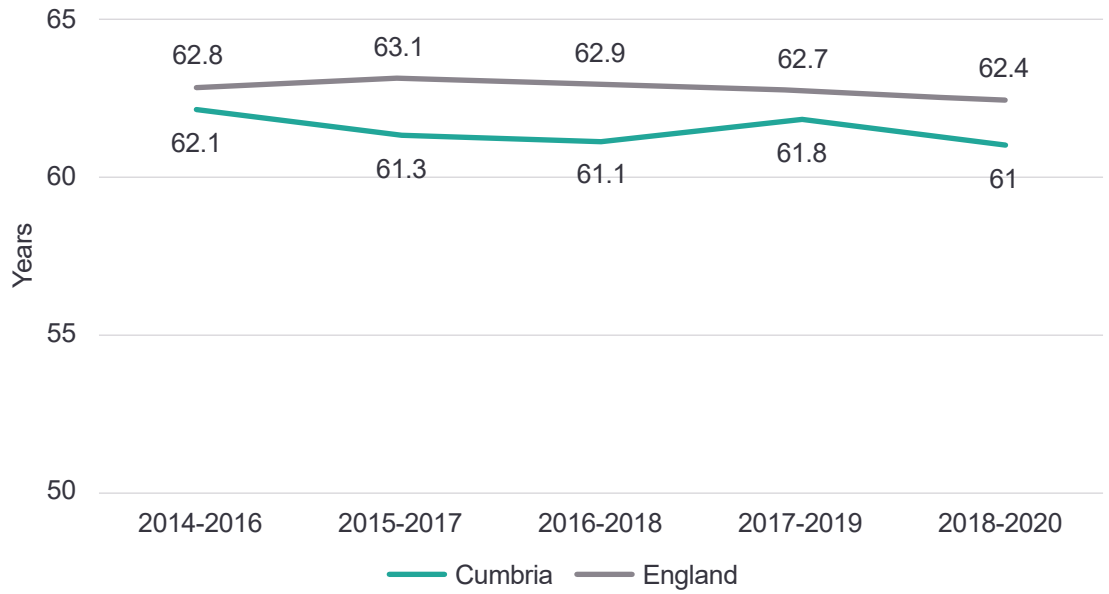
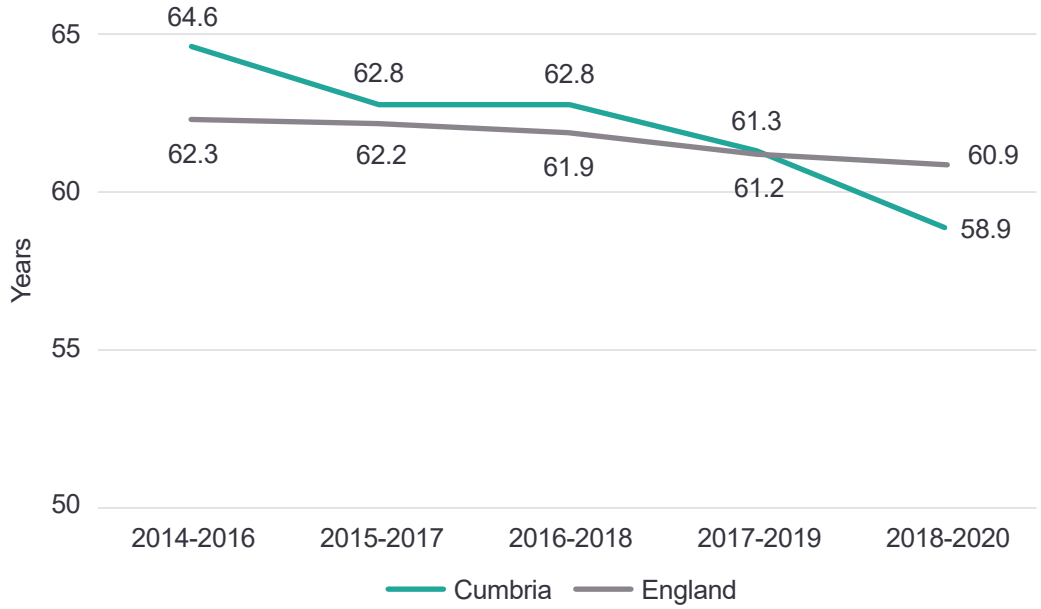


Figure 2.9: Disability free life expectancy for females in Cumbria compared to England, 2014-2016 to 2018-2020[1].



2.8 Many of the diseases that cause ill health and early deaths are associated with shared preventable risk factors

Disability adjusted life years (DALYs) provide a measure of the impact of ill health on the life of the population, by assessing both the years lost because of premature death to a disease as well as the years of life adversely impacted by disease. One DALY represents the loss of one year of healthy life in the population.

The five leading causes of DALYs have remained constant between 1990 and 2021 and include ischaemic heart disease, diabetes, lung cancer, stroke and COPD[5]. The number of years of healthy life lost caused by ischaemic heart disease has fallen by 62%, whereas the number of years of healthy life lost caused by diabetes has increased by 107% between 1990 and 2021[5].

Potentially preventable risk factors accounted for a third of the 70,750 years of healthy life lost across Cumbria in 2021[5]. Smoking, high alcohol use and high blood pressure remain leading attributable risk factors for DALYs[5]. There has been a notable increase in years of healthy life lost caused by drug use in men and women aged 15-49, as well as having a high body mass index and high fasting plasma glucose[5].

Figure 2.10: Leading risk factors for disability adjusted life years (DALYs) for males in Cumbria in 2021, by age group[5].

Risk factors for DALYs, males, 15-49 in Cumbria in 2021		% of total DALYs (% Change 1990-2021)
1/	High alcohol use	9.2% (-17.3%)
2/	Drug use	9% (+129.8%)
3/	High body mass index (BMI)	5.7% (+15.8%)
4/	Smoking	4.1% (-55.1%)
5/	High fasting plasma glucose	4% (+131.2%)

Risk factors for DALYs, males, 50-74 in Cumbria in 2021		% of total DALYs (% Change 1990-2021)
1/	Smoking	14.1% (-52.1%)
2/	High body mass index (BMI)	9.9% (+0.9%)
3/	High blood pressure	8.2% (-67.3%)
4/	High fasting plasma glucose	8.2% (+21.2%)
5/	High alcohol use	5.6% (+122.2%)

Risk factors for DALYs, males, 75+ in Cumbria in 2021		% of total DALYs (% Change 1990-2021)
1/	High blood pressure	10.1% (-64.6%)
2/	Smoking	9.7% (-56.6%)
3/	High fasting plasma glucose	8.3% (-6.5%)
4/	High body mass index (BMI)	6.7% (+6.9%)
5/	Kidney dysfunction	4.9% (-35.6%)

Figure 2.11: Leading risk factors for disability adjusted life years (DALYs) for females in Cumbria in 2021, by age group[5].

Risk factors for DALYs, females, 15-49 in Cumbria in 2021		% of total DALYs (% Change 1990-2021)
1/	High body mass index (BMI)	4.9% (+47.7%)
2/	Drug use	4.2% (+131%)
3/	High alcohol use	3% (+11.2%)
4/	High fasting plasma glucose	2.9% (+132.6%)
5/	Smoking	2.8% (-52%)

Risk factors for DALYs, females, 50-74 in Cumbria in 2021		% of total DALYs (% Change 1990-2021)
1/	Smoking	11% (-41%)
2/	High body mass index (BMI)	9.5% (+6.8%)
3/	High fasting plasma glucose	6.5% (+29%)
4/	High blood pressure	4.1% (-75.1%)
5/	High low-density lipoprotein (LDL) cholesterol	2.2% (-74.6%)

Risk factors for DALYs, females, 75+ in Cumbria in 2021		% of total DALYs (% Change 1990-2021)
1/	High blood pressure	9.7% (-68.8%)
2/	Smoking	8.5% (-18.3%)
3/	High fasting plasma glucose	7.7% (-9.8%)
4/	High body mass index (BMI)	7.5% (+10.2%)
5/	Kidney dysfunction	4.4% (+42.4%)

2.9 Summary

While the overall health of people in Westmorland and Furness is relatively good, there are persistent inequalities in life expectancy and ill health. People living in the most deprived areas of Westmorland and Furness have the lowest life expectancy and highest risk of early preventable death, compared to those living in the least deprived areas. Furness has the lowest life expectancy at birth and the gap is widening, with women disproportionately affected. Although there has been a steady increase in overall life expectancy in previous years, there was a reduction in life expectancy across all localities during the COVID-19 pandemic. Despite improvements in recent years, the rate of preventable death has increased back to rates which were last seen in 2010-12. The amount of time people spend in poor health has also increased, with a notable increase in years of healthy life lost caused by drug use in men and women aged 15-49, as well as having a high body mass index and a high fasting plasma glucose.

2.10 Recommendations

Health inequalities, and the action needed to address them have been well understood for many years; however, this evidence base has not been consistently translated into action and as a result inequalities are widening.

Considerations of health equity need to be at the forefront of decision making in all sectors, with policy, service design and investment decisions aligned to the actions recommended by the Health Equity Commission for Lancashire and Cumbria in the 2022 report [2].

References

1. Office for Health Improvement and Disparities. Public health profiles. [Internet]. 2024. Available from: https://fingertips.phe.org.uk/ © Crown copyright 2024
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3. What causes ill health and why does it differ by where we live?

3.1 Our health and wellbeing is shaped by multiple factors, including our life experiences and the building blocks of health and wellbeing

Good health encompasses our physical, mental, social and emotional wellbeing and is not solely the absence of disease or illness[1]. It is our greatest and most fundamental asset and is shaped by multiple factors which interact from before we are born and throughout the duration of our lives, termed the "determinants of health" (Figure 3.1)[2]. These include our biology and genetics, our health related practices, and our life experiences, including our access to and experiences of healthcare services and the environments in which we live[2].

Figure 3.1: The Dahlgren-Whitehead model of health determinants [2,4].

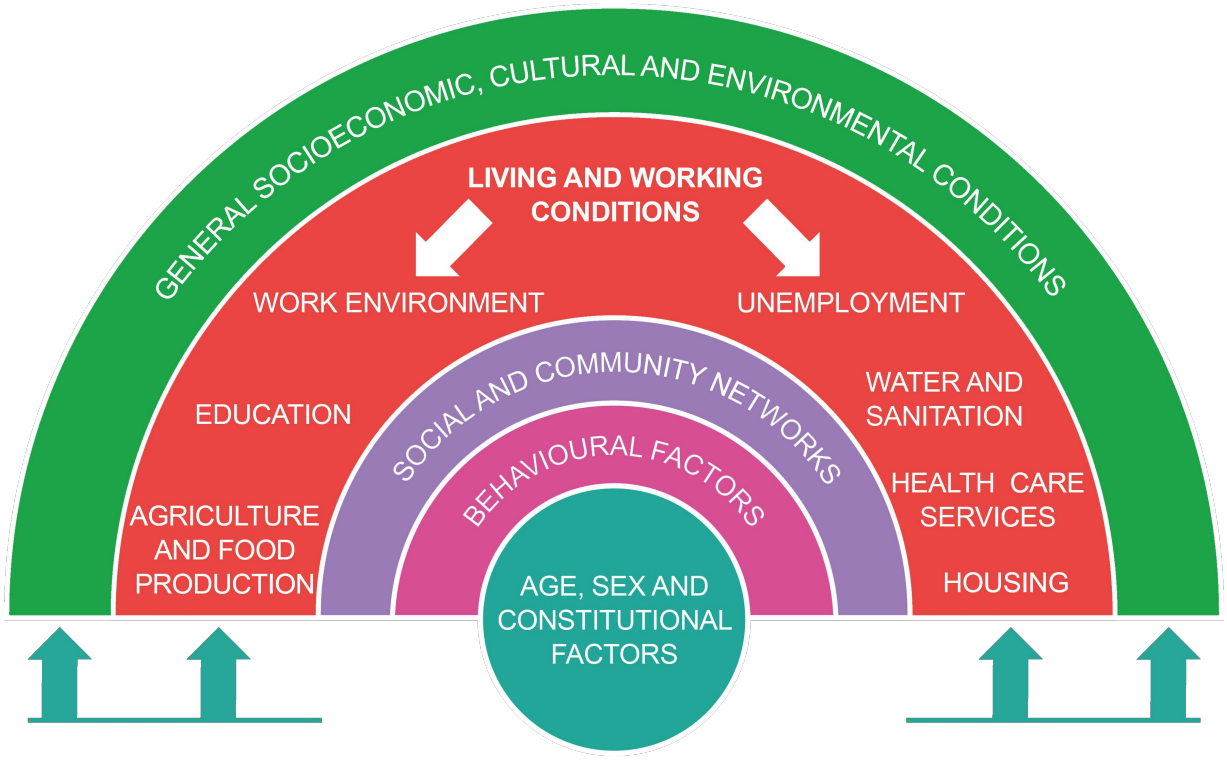


Image source: The Health Foundation[4]

However, these factors do not contribute to our health equally. It is the conditions in which we live that have the greatest overall impact on the health of the population[3]. Estimated to account for around half of the overall health of the population, these can be thought of as the 'building blocks' of health and wellbeing, encompassing our experiences of poverty and discrimination, our access to education, fair work and safe and warm homes and the characteristics of the places in which we live, including our access to public transport, safe communities and green spaces[4]. These building blocks are fundamental to our health and wellbeing: they influence our ability to access services and goods that promote health and wellbeing, determine our exposure to risk factors that may harm our health and provide resilience to deal with unexpected changes in our circumstances or lives[4]. When any of these building blocks are missing or unstable, it becomes much harder to stay healthy and well[4].

These factors also do not act in silo, as the clearly distinct and defined layers of the rainbow seen in Figure 3.1[2]. The system in which our health is developed is complex and ever-changing, with each 'layer' of the determinants of health simultaneously interacting and influencing the others[2]. For example, the building blocks of health and wellbeing also shape our health related practices both directly and indirectly, including smoking rates, alcohol consumption and diet.

3.2 The strength of the building blocks of health and wellbeing are not equal across society, leading to health inequalities

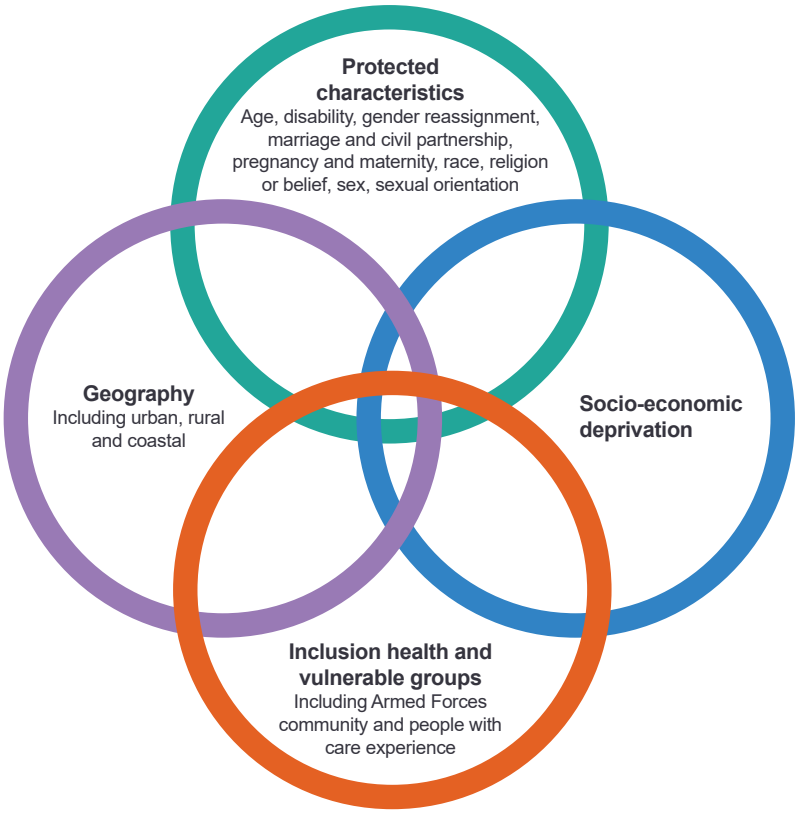
Health inequalities are a direct consequence of the unequal conditions and places in which people are born, develop, live, work and age and lead to unfair, avoidable and systematic differences in the health and wellbeing of different groups and communities in the population[5].

Some of the factors that can place individuals and communities at risk of experiencing health inequalities include[5]:

- Differences in our characteristics including age, disability, ethnicity, gender and sexual orientation.
- The geographical location of where we live, including living in rural or coastal environments.
- The characteristics of the places in which we live, particularly our experiences of social and economic deprivation and poverty.
- Being socially excluded, experiencing multiple overlapping risk factors for poor health, or poor access to health and care services; for example, people experiencing homelessness, armed forces communities and care experienced young people.

These factors are not experienced in isolation but intersect throughout a person's life, resulting in some people experiencing multiple disadvantages impacting on their health (Figure 3.2).

Figure 3.2: Some of the factors that can place individuals and communities at risk of experiencing health inequalities and their intersection.



3.3 Recent societal challenges, including the COVID-19 pandemic and the cost of living crisis, have exposed and widened existing health inequalities

Health inequalities result in differences across society in how long an individual lives and how many years they spend in good health[5]. They are present at all stages of the life course, including impacting on children and young people, and have been compounded by recent significant societal events[6]. Neither the COVID-19 pandemic nor the cost of living crisis have been felt equally[6]. The COVID-19 pandemic disproportionately impacted people living in the most deprived areas, ethnic minority groups and people with pre-existing long term health conditions, resulting in higher mortality rates and lasting adverse impacts on physical and mental health (Figure 3.3)[6]. This has been followed by the cost of living crisis, placing more people and families at risk of poverty, inequalities and poor health[6].

Figure 3.3: Model of the pathways to inequalities experienced during the COVID-19 pandemic.

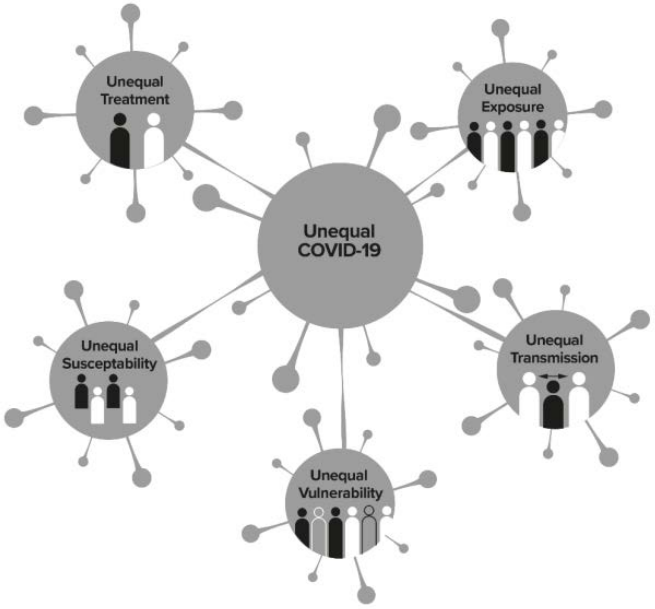


Image source: Bambra C, Munford L, et al (2023) County Durham and Tees Valley: Health, Wealth and (Unequal) Opportunities to Thrive, Health Equity North and the County Durham Community Foundation, page 27.

People living in Westmorland and Furness were unequally impacted by the COVID-19 pandemic[7]. Rates of admission to hospital and deaths involving COVID-19 were significantly higher for people living in the most deprived areas in Cumbria compared to the least[7]. Age-standardised rates account for differences in the population size and age-structure, evening out changes to allow comparison between population groups. The age-standardised rate for total admissions to hospital for COVID-19 in Cumbria between March 2020 and November 2022 was twice as high for those living in the most deprived areas compared to the least deprived areas (Figure 3.4)[7]. The age-standardised mortality rate for deaths involving COVID-19 in Cumbria between March 2020 and January 2023 was 1.8 times higher for those living in the most deprived areas compared to the least (Figure 3.5)[7].

The age-standardised mortality rate for deaths involving COVID-19 in Cumbria between March 2020 and January 2023 was significantly higher for males in Cumbria (430.5 per 100,000 population) compared to females (280.9 per 100,000 population)[7]. National data shows that ethnic minority populations were at higher risk of admission to intensive care and mortality from COVID-19[7].

Figure 3.4: Cumulative age-standardised hospital admission rate per 100,000 population, for COVID-19 in Cumbria, by local authority deprivation quintile, for all ages, March 2020 to November 2022[7].

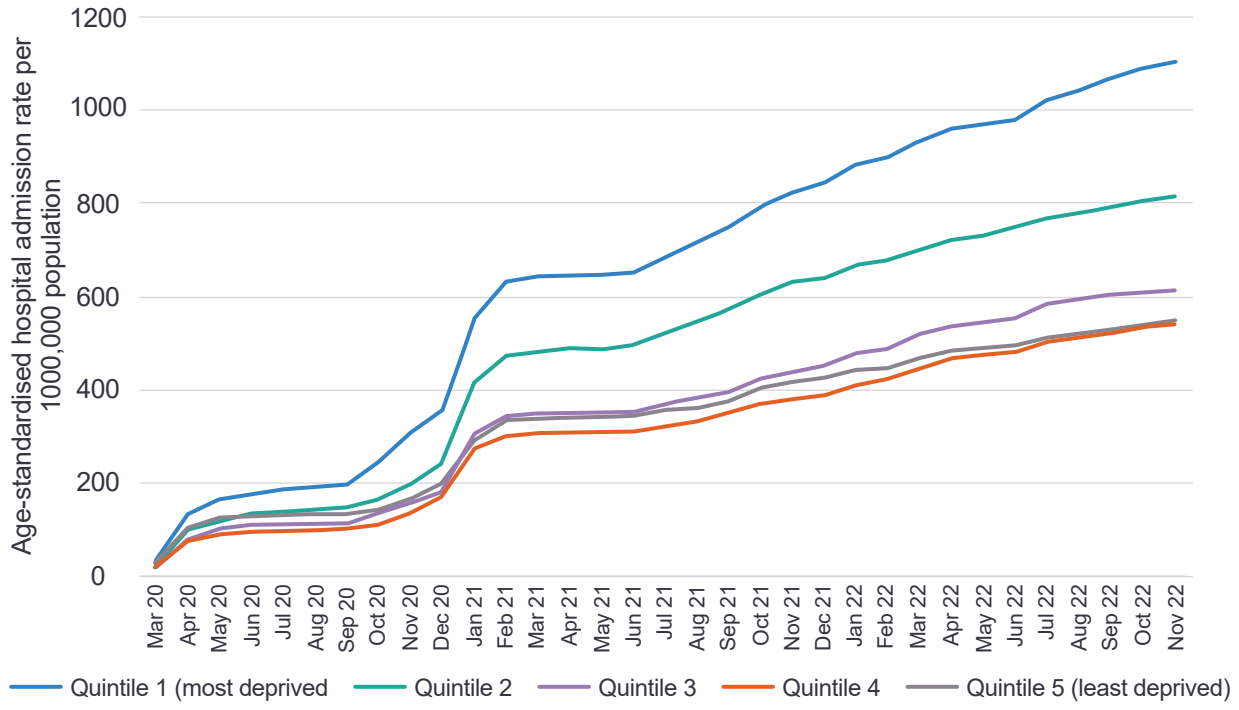
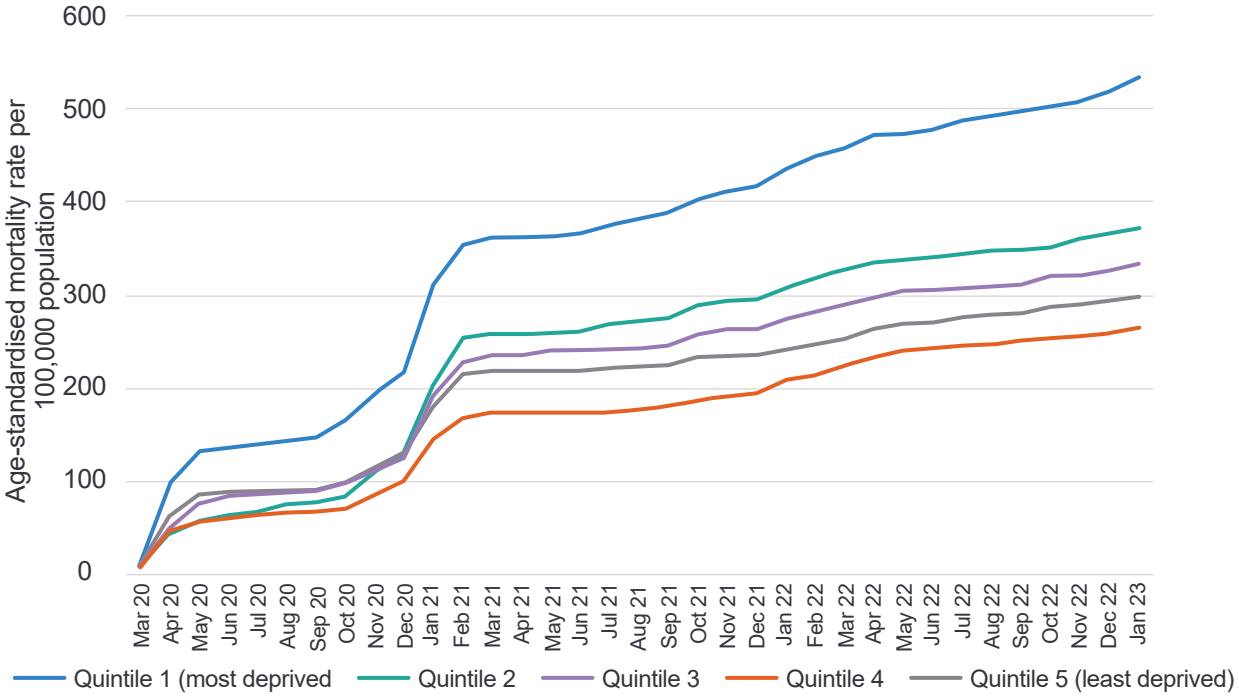


Figure 3.5: Cumulative age-standardised mortality rate per 100,000 population, for deaths involving COVID-19 in Cumbria, by local authority deprivation quintile, for all ages, March 2020 to January 2023[7].



3.4 Ill health, early deaths and inequalities are not inevitable. We must focus on preventing disease to support people to live in better health for longer

Life expectancy has improved significantly over the last century[8]. In 1924, life expectancy in England was 56.2 years for men and 60.1 years for women; today this is 79.3 years for men and 83.2 years for women[8]. The greatest gains in life expectancy were achieved in the early 20th century and are attributed to universal improvements in living conditions, including the availability of clean water, economic growth and improved nutrition[9]. Additional improvements in life expectancy in the later 20th century largely resulted from the recognition of the risk factors for, and treatment of, preventable disease, including heart disease and strokes[9].

This has underpinned our knowledge of the determinants of health discussed earlier in this chapter; crucially, that it is improvements to the conditions in which we live that have the greatest overall impact on our health (the outer layers of the model of health determinants in Figure 3.1), followed by reduction of risk factors through changes to our health related practices and then treatment of established ill-health and disease[2,10].

Prevention of ill health and disease is a fundamental component of Public Health, and describes any action taken to support people to stay healthy and well and reduce the risk of ill health and early death[11]. It is important to recognise that there is not a 'one size fits all' approach to prevention, but that prevention approaches instead comprise a series of levels of support and interventions across the life course to meet the health needs of the population as we are born, develop, live and age[11]. This is represented by the prevention pyramid in Figure 3.6[11]. Prevention actions at the base of the pyramid (termed primordial and primary prevention) have universal benefits for the whole population, whereas prevention actions at the top of the pyramid (termed secondary and tertiary prevention) are targeted more to at-risk and affected individuals[11].

Primordial prevention approaches seek to improve the building blocks of health and wellbeing, including poverty, housing, food environments and pollution, and thereby prevent the development of risk factors for ill health from ever occurring[12]. Primary prevention focuses on recognising and modifying existing risk factors for ill health, such as low levels of physical activity or smoking, to reduce the risk of ill health developing[12]. Secondary prevention approaches aim to detect and treat early pathological changes, such as high blood pressure or diabetes, before symptoms develop[12]. Secondary prevention becomes increasingly important as we age and are at increased risk of ill health in order to halt and delay the progression of ill health and disease to enable people to live with better health for longer[9]. Tertiary prevention approaches are focussed on people with established ill health and disease and aim to improve quality of life and reduce the risk of future recurrence[12].

Figure 3.6: The prevention pyramid

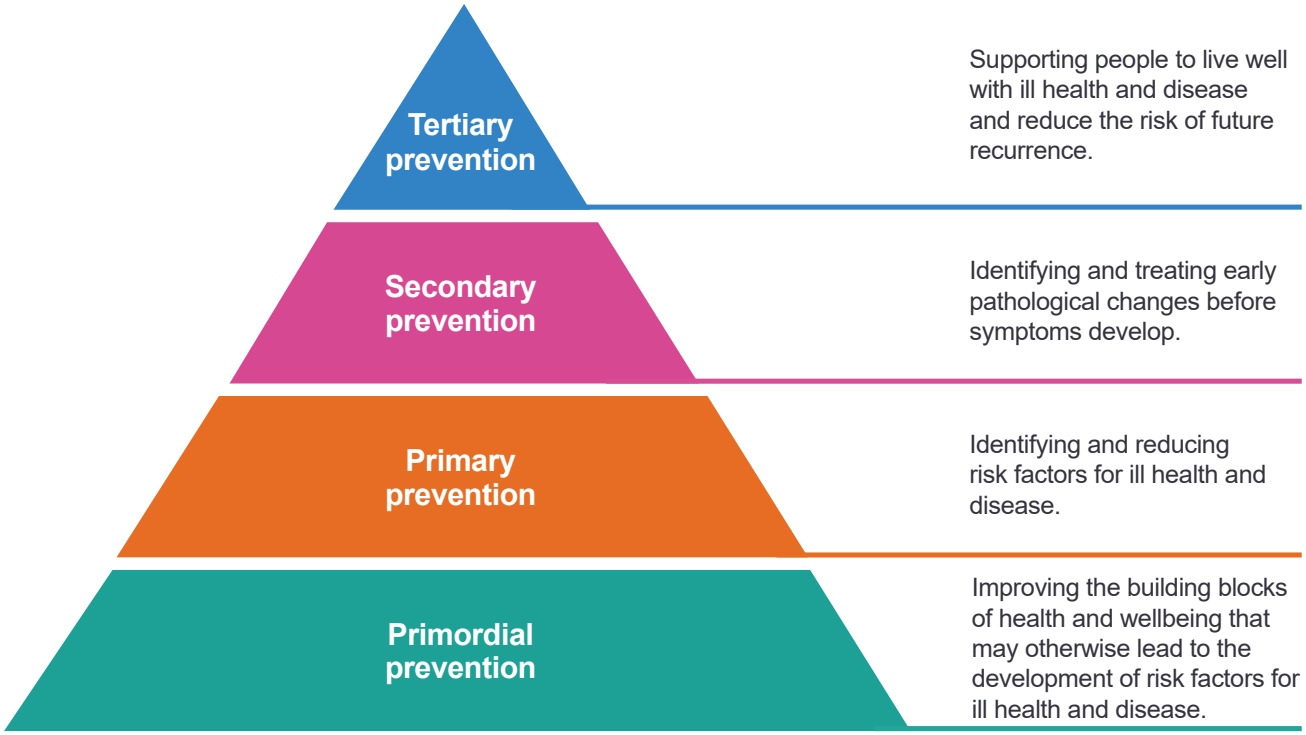


Figure 3.7: The impact of the building blocks of health and wellbeing on the development of ill health throughout the life course with opportunities for prevention.

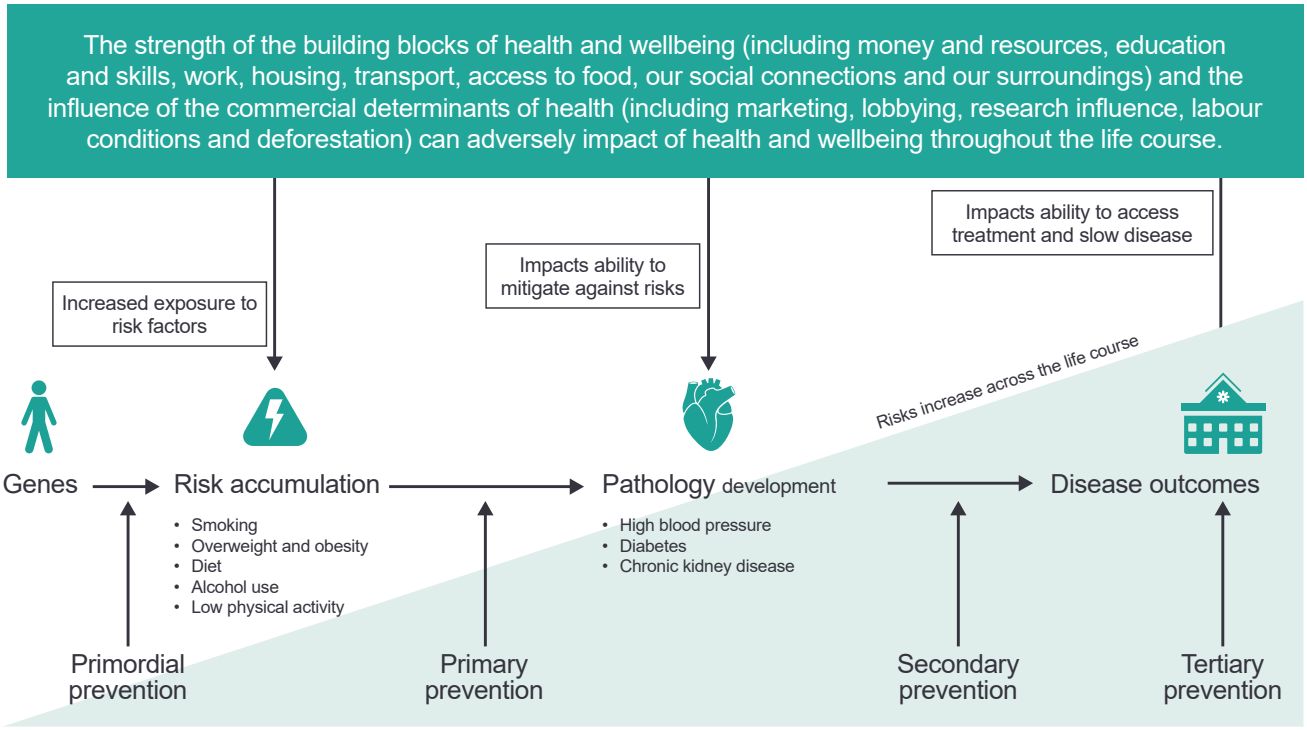


Image adapted from: Walsh S, Merrick R, Brayne C. The relevance of social and commercial determinants for neurological health. Lancet Neurol. 2022 Dec;21(12):1151-1160. doi:10.1016/S1474-4422(22)00428-8. PMID: 36402161.

3.5 Summary

In summary, this chapter has described how our health and wellbeing is shaped by our life experiences and the places in which we are born, work, live and age. These are the building blocks of health and wellbeing and impact our health throughout the life course, beginning from before we are born. It has explained that our approach to preventing ill health must reflect our knowledge of these causes, and that prevention at all stages of life can delay disease onset and improve quality of life (Figure 3.7). The following chapters take a life course approach to describe the challenges to our current and future health in Westmorland and Furness to identify how we can prevent ill health and reduce inequalities for our population.

3.6 Recommendations

Across Westmorland and Furness we need to take a 'Health In All Policies' approach, considering the opportunities to improve and protect health in all decision making on the building blocks of health, including (but not limited to) 'economic, housing and planning policy.

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4. Poverty and Deprivation

Westmorland and Furness is the third largest unitary authority in England and is home to over 225,000 people spread over rural and coastal towns, villages and communities[1]. We have many strengths: our natural resources and landscape, our strong and diverse economy and our people and communities. We also face challenges as England's most sparsely populated local authority, with around 34,000 people living in rural areas[1].

Exposure to poverty and deprivation is one of the central drivers of health inequalities[2]. Financial insecurity makes it difficult to access many of the other essential building blocks of health including housing, warmth and food and has adverse impacts on physical and mental wellbeing[3]. Consequent poor health can make obtaining employment more difficult, further impacting people's opportunities and outcomes[3].

4.1 Deprivation in Westmorland and Furness

In England, the Index of Multiple Deprivation (IMD) provides the predominant measure of relative levels of deprivation for neighbourhoods and was last updated in 2019[4]. A neighbourhood is geographically described as a lower-layer super output area (LSOA) that comprises a small area which is home to approximately 1,500 people; there are 32,844 LSOAs in England[4]. The IMD provides a score for each neighbourhood based on factors including income, employment, education, crime, our living environment and barriers to housing and services[4].

Westmorland and Furness is a relatively affluent place with overall low levels of deprivation[5]. However, there are a number of areas where people are adversely impacted by deprivation, which are not equally spread across Westmorland and Furness[5]. Figure 4.1 shows IMD deciles for small areas (LSOAs) in Westmorland and Furness[5]. The darker green neighbourhoods on the map are areas of higher deprivation and they concentrate in Furness, as well as some areas in Eden.

Around 1 in 4 (24.5%) small areas in Furness are in the most deprived 10% of small areas nationally and just over 1 in 2 (51%) are in the most deprived 30% nationally[5]. Overall, Furness was the 31st most deprived lower tier local authority in 2019 (out of 317, prior to local government reorganisation in Cumbria)[5]. However, according to the local concentration measure, which ranks areas by the deprivation experienced by the most deprived 10% of the local population, Furness is the 9th highest in England, and for the health deprivation and disability measure, Furness is the 4th highest in England[5].

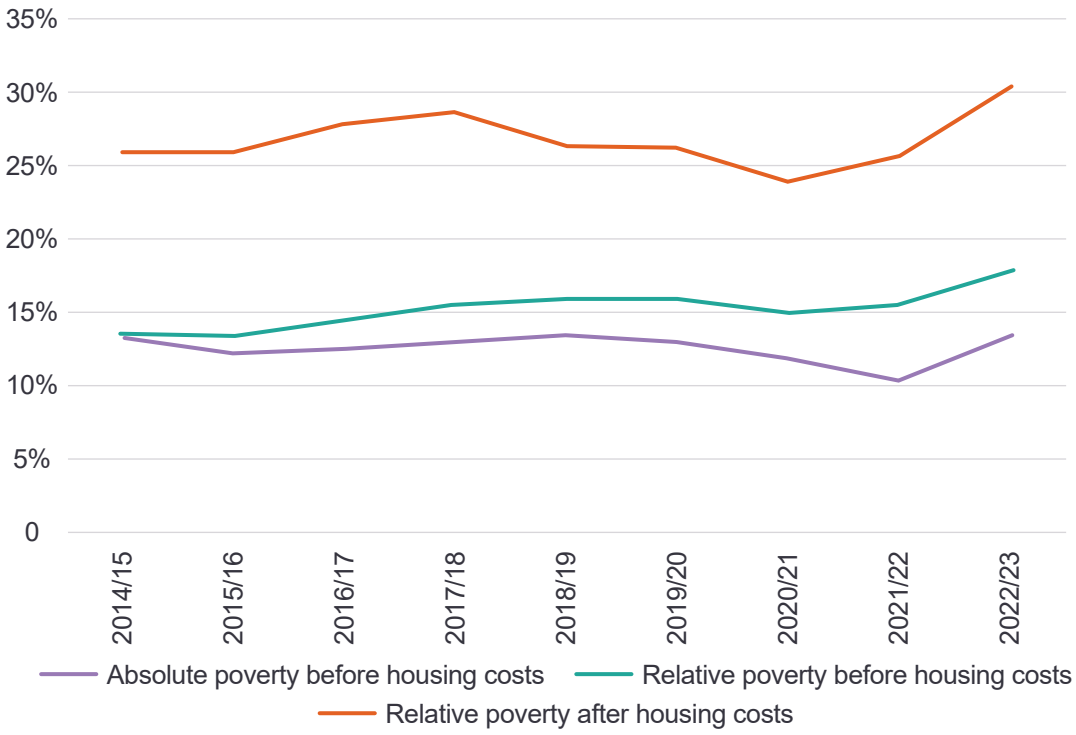
Eden and South Lakeland have much lower overall IMD scores and rank 186th and 250th of all local authorities respectively[5]. However, it is recognised that our rural communities face specific challenges that may not be visible in these national measures to assess deprivation, as small areas of deprivation are less likely to be identified in an area with greater geographical spread than an urban area.

4.2 Three in every ten children live in Westmorland and Furness live in relative poverty after housing costs are accounted for

Poverty is measured in different ways in national statistics. Absolute poverty is defined as families living in households with children under 16 with an income below 60% of the median income in 2010/11, which has been adjusted for inflation. Relative poverty is defined as families within children under 16 whose household income is below 60% of the current median income. These measures can then be adjusted for housing costs to more accurately reflect current financial pressures, as well as considering the impact of high housing costs in some areas.

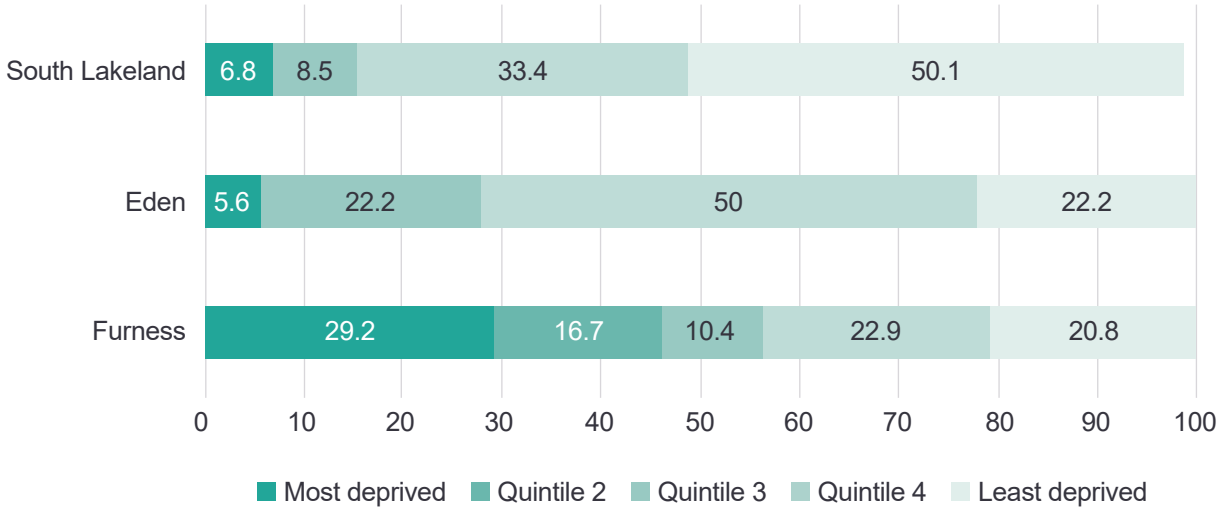
In 2022/23, there were 12,037 children in Westmorland and Furness living in relative poverty after housing costs are accounted for: this is 3 in every 10 children (Figure 4.2) (5).

Figure 4.1: Child poverty rates in Westmorland and Furness, 2014/15 – 2022/23[5].



An alternative measure of child poverty is the Income Deprivation Affecting Children Index (IDACI), which was produced as part of the English Indices of Deprivation in 2019. If income deprivation affecting children was spread equally across England, each local authority area would be expected to have 20% of small areas in each quintile of deprivation. In Furness, almost three in every ten small areas (29.2%) are in the most deprived quintile for the IDACI (Figure 4.3)[5].

Figure 4.2: Percentage of small areas (lower layer super output areas, LSOAs) in each quintile for the Income Deprivation Affecting Children Index (IDACI)[5].

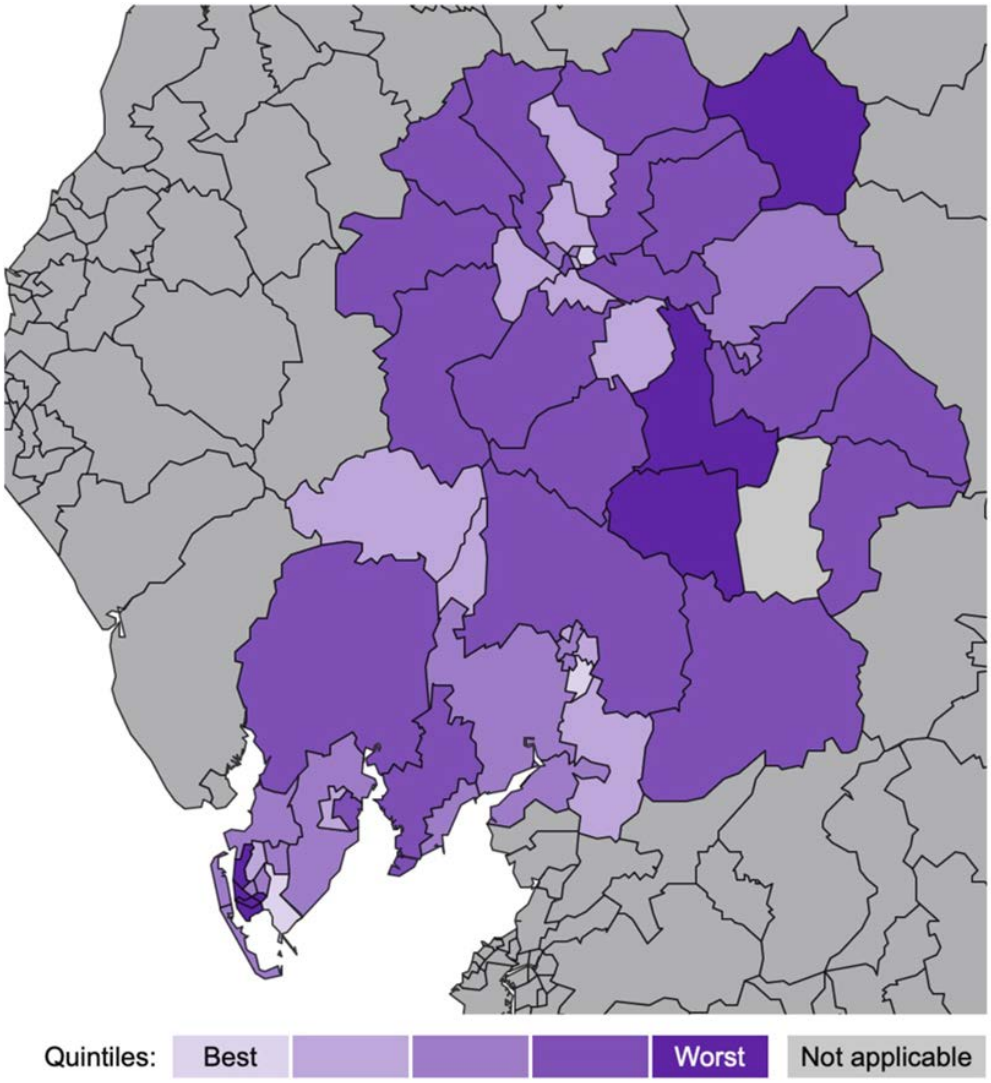


4.3 More households in Westmorland and Furness are estimated to be living in fuel poverty than the national average

Fuel poverty and cold homes are associated with an increased risk of excess winter deaths, as well as adverse effects on physical and mental health and wellbeing[6]. Higher proportions of households are estimated to be living in fuel poverty in Westmorland and Furness than the national average (13%)[5]. A household is classified as being in fuel poverty if the household's fuel poverty energy efficiency rating is band D or below and their disposable income (after housing and fuel costs) is below the poverty line[6].

15% of households in Eden, 17% of households in Furness and 13% of households in South Lakeland meet this classification (Figure 4.4)[5]. Eight small areas (LSOAs) in Furness have levels of fuel poverty which are more than twice the national average[5]. In Barrow Central: Central LSOA, 32% of households are estimated to be living in fuel poverty[5]. Three electoral wards (pre-2023 ward boundaries) in Eden have levels of fuel poverty which are in the highest quintile nationally: Alston Moor, Crosby Ravensworth and Orton with Tebay[5].

Figure 4.4: Map to show modelled estimates of the proportion of households in fuel poverty by electoral ward in Westmorland and Furness, 2020[5].



4.4 Older people living in poverty

The natural beauty of the landscapes, rural areas and coastal areas across Westmorland and Furness are well recognised and bring many benefits for health and wellbeing. However, growing older in rural and coastal areas can present unique challenges to health and wellbeing, including isolation, difficulties with accessibility and transport, and poverty[7]. The Income Deprivation Affecting Older People Index provides a measure of older people living in poverty and describes the proportion of all those aged 60 or over who experience income deprivation.

In England, 14.2% of older people are living in poverty[5]. Both Eden and South Lakeland have significantly lower levels of older people living in poverty (7.6% and 7.4% respectively) than the national average, whilst Furness has a significantly higher level of older people living in poverty (14.7%) than England[5]. However, there are smaller areas of Westmorland and Furness which have much higher proportions of older people living in poverty that are masked by larger geographical areas; these include the electoral wards of Hindpool (29.5%), Central (25%), Ormsgill (23.8%), Penrith Pategill (19.9%), Risedale (18%) and Walney North (17.7%)[5].

Case study: Health and Wellbeing Coaches

Our Health and Wellbeing Coaches were established in 2016 and comprise a highly skilled workforce who work with individuals and their families across Westmorland and Furness. The team support people to live well by addressing factors that influence their health and well-being and building on their capacity to be independent, resilient and maintain good health for themselves and those around them.

The team work collaboratively with a range of partners across Westmorland and Furness to deliver outcome-focussed and needs-led support to individuals, with a particular focus on supporting people living in areas of high deprivation and need. The team comprises 21 coaches and officers and all coaches have undertaken a bespoke level 6 training programme in Health Coaching through the University of Cumbria.

Between April and December 2023, over 900 people were referred to the Health and Wellbeing Team. During this time, 74% of the people supported by the Health and Wellbeing Team reported that their levels of anxiety improved following support from one of the coaches, 70% reported reduced symptoms of depression, 80% reported improved happiness and 78% reported improved personal resilience.

Customer feedback taken from end of support questionnaire

"The sessions with my HAWC are really productive, useful and I like that there are some weekly activities arranged with HAWCs such as the walk in the park or the sessions with the Barrow Raiders."

"My HAWC has a wealth of information about the town which has helped me a lot, especially as I moved here to be safe from a stalker without friends or family."

"Getting me sorted out and got me back to being outgoing, helped me to meet new people and I enjoy a good laugh at the groups."

"By listening and being supportive and helpful to have someone there, helped me to get out of the house and my relationships are better."

"I didn't go anywhere for three years because of extremely bad physical and mental health which wiped out all my confidence. Since working with my HAWC, I'm more able to conquer my fears because I've gained mental strength and confidence to do things. Instead of saying I can't do something, I push the fear to the back and make myself do it. I now go to cafes with people in my local community, I stayed in a hotel in Keswick with a friend and I took the boat to the Isle of Man with my sister-in-law. I still can't do every I'd like to because my physical health prevents me from doing more but, I'm doing more than I was before working with my HAWC and now, I say yes to invitations to go out and do nice things more often. I'm also more positive now."

My HAWC was very understanding and caring. With her help, I achieved a lot in a relatively short space of time."

"I am able to go out more and be involved in different groups and I have found something that I can attend with my wife so we can spend more time together"

"I have joined a community art group which is introducing me to push myself to socialise as well as doing something I enjoy"

"I have began to go out more and push myself in uncomfortable settings"

"I am meeting friends"

"You provide support in almost all areas and you have an amazing team that are kind and supportive and trustworthy"

"All good - I didn't know that this support was available so it is really good that this service is there and willing to give people the help they need"

"I've found working with L extremely helpful; I've learnt to understand my needs more mentally and physically. That it's OK to rest and not always be on the go regardless of my age. I've also learnt that it's OK to say no to seeing people or doing too much. I've become better at managing my anxiety when things get really tough, for example: breathing exercises. I've become better at planning things such as work and general life, making everything seem less intense/overwhelming, which is what usually causes me to get anxious and flop in energy. I've also found ways to handle my ongoing illness. With all of the above, I've been able to work out a solution with work when I start to feel stressed or weary, planning ahead so I'm not worried about being off sick. Last thing I've also learnt is that my life is my own."

The team offer an open referral system and accept referrals from individuals and voluntary organisations. The team can also be accessed at certain times within the libraries across Westmorland and Furness. Please see the **website** for further information.

4.5 Summary

Exposure to poverty and deprivation is one of the central drivers of health inequalities. Rurality also presents unique challenges for Westmorland and Furness. Around 1 in 4 areas within Furness are considered to be amongst the most deprived areas of the country. Three in 10 children in Westmorland and Furness are living in relative poverty after housing costs are accounted for, and more households are estimated to be living in fuel poverty than the national average. Although Eden and South Lakeland have significantly lower levels of older people living in poverty compared to the national average, Furness has significantly higher levels.

4.6 Recommendations

Given the significant impact of poverty on health and wellbeing, there needs to be concerted effort to prevent poverty and mitigate its impact, including 'poverty proofing' public services. Action to address poverty should be informed by, and co-produced with, people with lived experience of poverty.

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5. Starting Well

5.1 Context

Inequalities experienced in the early years, childhood and adolescence have ongoing impacts on our health and opportunities throughout our lives[1]. In particular, it is now well recognised that the first 1001 days of life (from pregnancy to age 2) are critical for our physical, cognitive and emotional development[1]. The first 12 months of life are the peak period for brain development, in which neural connections rapidly form to develop sensory pathways for vision, hearing, language skills and cognitive functions[1]. Research has identified that up to a million neural connections form during every second of the first 12 months of life, and this is therefore the period in which the brain is most plastic[1]. Experiences and environments in these first days of life influence the development of the brain and can have a lifelong impact on social and emotional health[1].

5.2 Pregnancy outcomes

Healthy pregnancies result in improved maternal health outcomes and give children the best start in life. Smoking in pregnancy is a critical modifiable risk factor for pregnancy outcomes[2]. However, progress on reducing rates of smoking during pregnancy has stalled[3].

Figure 5.1: Percentage of mothers known to smoke at the time of delivery in Furness, Eden, South Lakeland and England[3].

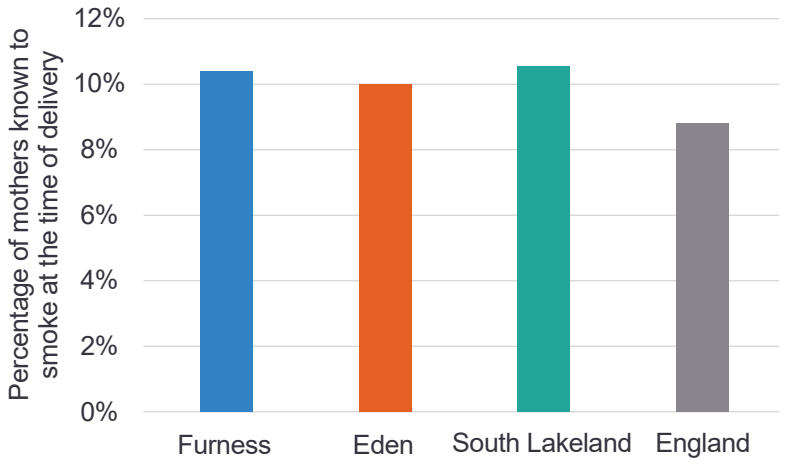

Table 5.1: Key indicators of health and wellbeing for pregnancy and the postnatal period in Westmorland and Furness, North-West and England[3]. *Red boxes indicate significantly higher outcomes than the national average, orange boxes indicate outcomes that are similar to the national average and green boxes indicate significantly lower outcomes than the national average.*

Key Indicator	Westmorland and Furness	North West	England
Infant mortality rate, 2020-22	2.5	4.4	3.9
Child mortality rate (1-17 years), 2020-22	14.1	11.8	10.4
Low birth weight of term babies, 2022	2.4%	2.8%	2.9%
Smoking status at the time of delivery, 2023/24	8.3%	8.4%	7.4%
Brestfeeding prevalence at 6-8 weeks, 2023/24	46.1%	45.9%	52.7%

Several of the key indicators of health and wellbeing for pregnancy and the postnatal period are listed in Table 5.1[3]. Infant mortality was previously declining in England but has stalled since around 2013[3]. The infant mortality rate in Westmorland and Furness is 2.5 per 1,000 live births, which is similar to the England rate[3]. The child mortality rate in Westmorland and Furness is also similar to the national average[3].

The rate of deliveries to mothers aged between 12 and 17 is significantly higher than the national average in Furness [3]. Between 2016/17 and 2020/21 in Barrow Central MSOA, over 1 in every 20 deliveries (5.5%) were to mothers aged between 12 and 17[3]. Supporting young families is vital: mothers aged between 12 and 17 are three times more likely to suffer from post-natal depression and experience poor mental health for up to three years after birth, and young families are at increased risk of living in poverty[4].

Perinatal mental health problems affect between 10 to 20% of women during pregnancy and the first year after having a baby[5]. In 2019-20, the MBRAACE Confidential Enquiry into maternal deaths in the UK and Ireland found that mental health related causes were the fourth highest cause of death for mothers in the first 6 weeks after having a baby, after COVID-19, cardiac disease and blood clots[6].

The report also found that deaths from mental health related causes are the leading cause of maternal deaths between six weeks and a year after the end of pregnancy, accounting for 40% of maternal deaths[6]. Maternal suicide is sadly the leading cause of direct deaths in this period[6]. Furthermore, 12% of the women who died up to a year after pregnancy in the UK in 2019-2020 were considered to be at severe and multiple disadvantage, which includes factors such as having a mental health diagnosis, experience of substance misuse and experience of domestic abuse[6].

5.3 Adverse childhood experiences

Adverse childhood experiences can be defined as "potentially traumatic events or chronic stressors that occur before the age of 18 and are uncontrollable to the child"[7].

Research conducted in 2020 sought to summarise the frequency that adverse childhood experiences occur at a local level, with a similar approach to how deprivation is quantified and ranked by the Index of Multiple Deprivation[7]. Higher ranks indicate an increased frequency of adverse childhood experiences (ACEs) in childhood[7]. The study found that Furness had a rank of 259 out of 324 for the frequency that ACEs occur in childhood, Eden had a rank of 96.5 and South Lakeland had a rank of 126[7].

Exposure to trauma and adverse childhood experiences has lifelong impacts on our health and wellbeing[1]. Recognising the impact of these early life experiences and offering early intervention and support to our children and families impacted by domestic abuse, trauma and adverse childhood experiences is key to improving outcomes.

5.4 Development and school readiness

Supportive early childhood development and education is key to acquiring the motor, cognitive, social and emotional skills children need to effectively learn when they begin to attend school. Children should receive a review at around 12 months old to monitor their growth and development and offer families an opportunity to discuss any concerns they may have about their child's physical, emotional and social needs. Children should then receive a further review of their health and development at 2 to 2.5 years old. At this review, the ASQ-3 (Ages and Stages Questionnaire 3) should be undertaken which assess five domains of child development, comprising communication, gross motor skills, fine motor skills, problem solving and personal-social development. These reviews also offer timely opportunities to discuss upcoming childhood vaccinations.

In Westmorland and Furness, the proportion of children receiving their 12 month review and 2 to 2.5 year review is significantly less than the national average (76.9% of children receiving the 12 month review compared to 86.5% of children in England; 71.9% of children receiving the 2 to 2.5 year review compared to 78.4% of children in England) (3). Significantly fewer children in Westmorland and Furness also receive the ASQ-3 at their 2 to 2.5 year review than the national average (84.5% of children in Westmorland and Furness compared to 93.3% in England) (Table 5.2)[3].

Table 5.2: Proportion of children receiving 12 month and 2 to 2.5 year health visitor reviews in Westmorland and Furness, North-West and England, 2023/24[3]. *Red boxes indicate significantly higher outcomes than the national average, orange boxes indicate outcomes that are similar to the national average and green boxes indicate significantly lower outcomes than the national average.*

2023/24	Westmorland and Furness	North West	England
Proportion of children receiving a 12-month review	76.9%	90.6%	86.5%
Proportion of children receiving a 2 to 2.5 year review	71.9%	83.7%	78.4%
Proportion of children aged 2 to 2.5 receiving ASQ-3 as part of the Healthy Child Programme or integrated review	84.5%	95.6%	93.3%

School readiness is a key determinant of health and wellbeing over the life course. The percentage of children who achieve a good level of development at the end of the Reception year is used as a proxy measure to assess if children were 'school ready'. Nationally, children who have greater experience of poverty and deprivation are at risk of poorer developmental outcomes[3].

Children in Westmorland and Furness experience significant inequalities in developmental and educational attainment[3]. Children receiving free school meals are less likely to achieve a good level of development at the end of Reception than those who do not (30.8% in Furness, 34.3% in Eden and 45.4% in South Lakeland)[3]. These trends are also present in the percentage of children who achieve the expected level of communication, language and literacy skills at the end of Reception and the percentage of children who meet the expected level across all early learning goals (Table 5.3)[3].

Table 5.3: Percentage of children achieving expected outcomes at the end of Reception by free school meals status in Furness, Eden and South Lakeland compared to England, 2022/23[3].

Indicator (2022/23)		England	Furness	Eden	South Lakeland
Percentage of children achieving a good level of development at the end of Reception	Not in receipt of free school meals	71.5%	64.2%	66.7%	69.8%
	In receipt of free school meals	49.1%	30.8%	34.3%	45.4%
Percentage of children achieving at least the expected level in communication, language and litercay skills at the end of Reception	Not in receipt of free school meals	73%	67%	70.2%	72.6%
	In receipt of free school meals	50.9%	33.3%	34.4%	50%
Percentage of children at expected level across all early learning goals	Not in receipt of free school meals	69.9%	53.9%	65.9%	69%
	In receipt of free school meals	47.1%	30.8%	34.4%	45.5%

5.5 Vaccinations

Vaccinations save lives and are one of the most important things we can do to protect children from serious diseases. Children are offered vaccines at different stages of childhood to protect against serious infections. The vaccines offered at 8, 12 and 16 weeks protect children against 9 different infections. Overall, in Cumbria in 2023/24, vaccination coverage reached or exceeded 90% coverage for vaccinations offered to 0-5 year olds (Tables 5.4 and 5.5)[3].

Table 5.4: Population vaccination coverage for 0-5 year olds in Cumbria, North-West and England, 2023/24[3]. *Red boxes indicate vaccination coverage of <90%, orange boxes indicate vaccination coverage of 90-95% and green boxes indicate vaccination coverage of >95%.*

Population vaccination coverage 2023/24	Cumbria	North West	England
Dtap IPV Hib HepB (1 year old)	96.2%	90.0%	91.2%
Dtap IPV Hib HepB (2 years old)	95.6%	91.8%	92.4%
PCV	96.2%	92.4%	93.2%
Hib and MenC booster (2 years old)	96.0%	88.2%	88.6%
PCV booster	96.2%	87.8%	88.2%
Hib and MenC booster (5 years old)	96.4%	93.6%	92.4%
MenB booster (2 years)	94.1%	86.5%	87.3%
MenB (1 year)	96.0%	89.7%	90.6%
DTap and IPV booster (5 years)	94.4%	82.5%	82.7%
Rotavirus (1 year)	93.7%	86.6%	88.5%

Table 5.5: Population vaccination coverage for MMR vaccines (measles, mumps and rubella) in Cumbria, North-West and England, 2023/24[3]. *Red boxes indicate vaccination coverage of <90%, orange boxes indicate vaccination coverage of 90-95% and green boxes indicate vaccination coverage of >95%.*

Population vaccination coverage 2023/24	Cumbria	North West	England
MMR for one dose (2 years old)	95.8%	88.6%	88.9%
MMR for one dose (5 years old)	97.2%	93.0%	91.9%
MMR for two doses (5 years old)	94.8%	84.5%	83.9%

The HPV vaccine is offered to protect children against HPV infection, which is associated with cervical cancer. HPV vaccination coverage is significantly below 80% coverage in Cumbria (Table 5.6)[3].

Table 5.6: Population vaccination coverage for adolescents (HPV and Men ACWY) in Cumbria, North-West and England, 2022/23[3]. *Red boxes indicate vaccination coverage of <90%, orange boxes indicate vaccination coverage of 90-95% and green boxes indicate vaccination coverage of >95%.*

Population vaccination coverage 2022/23	Cumbria	North West	England
HPV vaccination for one dose (12 to 13 year old, male)	66.5%	65.4%	65.2%
HPV vaccination for one dose (12 to 13 year old, female)	75.1%	72.2%	71.3%
HPV vaccination for two doses (13 to 14 year old, female)	65.2%	64.5%	62.9%
Meningococcal ACWY conjugate vaccine (14 to 15 year old)	88.3%	78.7%	79.6%

5.6 Summary

Inequalities in the early years, childhood and adolescence impact on future health outcomes and opportunities. Smoking during pregnancy, low birth weight and infant mortality are all important factors in child and maternal health, and rates in Westmorland and Furness are similar to national levels. However, 1 in every 20 deliveries in Barrow Central were to mothers aged between 12 and 17, which is significantly higher than the national average. Significantly fewer children in Westmorland and Furness receive a 12-month and 2-2.5 year review compared to the national average, and there are significant inequalities in children's school readiness and education attainment. Children in receipt of free school meals are much more likely to experience these inequalities. Westmorland and Furness does however have high vaccination rates in the early years, with over 90% uptake across all vaccines offered to under-5s. Rates for HPV vaccination which is offered to teenagers is however low, with uptake being substantially below 80%.

5.7 Recommendation

Actions to influence good health and wellbeing in the early years are key to reducing our risk of poor physical and mental health in adulthood, because our ability to adapt to changes in our environment reduces over time.

The first 1001 days of life are a critical time for physical, cognitive, and emotional development and therefore need to be given the highest priority in any strategies and programmes aiming to improve outcomes, and in the allocation of resources. There are some stark inequalities in outcomes for children and young people, and support for children and families, from early years through to adulthood, needs to be scaled appropriately to need in order to reduce these inequalities and improve outcomes for all.

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6. Developing Well

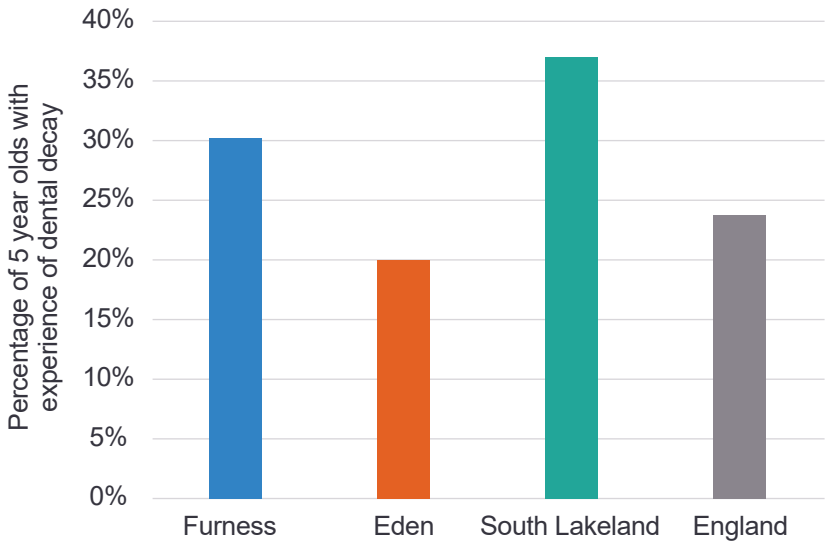
6.1 Oral health, healthy weight and physical activity

Oral health

Good oral health is a key component of overall health and wellbeing, impacting on physical health, social interactions and quality of life throughout the life course[1]. Poor oral health is largely preventable but remains a significant public health concern[1]. The oral health of children is monitored through the National Dental Epidemiology Programme. An oral health survey of 5 year old children is conducted every 2 years and the results from the 2022 survey are summarised in Table 6.1[2].

Overall, 37% of 5 year old children in South Lakeland, 30.2% of 5 year of children in Furness and 20% of 5 year old children in Eden had experience of dentinal decay in 2022[2]. The prevalence of dentinal decay in South Lakeland and Furness was significantly higher than the national average in 2022. (Figure 6.1)[2].

Figure 6.1: Percentage of 5 year olds with experience of dentinal decay in Westmorland and Furness and England, 2021/22[2].



At 5 years old, children normally have 20 primary teeth. Among children with experience of dentinal decay, children in Furness had on average 4.8 teeth with experience of dentinal decay, children in South Lakeland had on average 2.6 teeth with experience of dentinal decay and children in Eden had on average 3.2 teeth with experience of dentinal decay in 2022[2]. Analysis of national data in 2022 showed that 5 year old children living in the most deprived areas of the country were almost 3 times as likely to have experience of dentinal decay (35.1%) compared to children living in the least deprived areas (13.5%)[2].

Table 6.1: Key findings from the 2022 National Dental Epidemiology Programme for 5 year olds in Westmorland and Furness and England[2]. *Red boxes indicate significantly higher outcomes than the national average, orange boxes indicate outcomes that are similar to the national average and green boxes indicate significantly lower outcomes than the national average.*

2022	Furness	Eden	South Lakeland	England
Percentage of 5 year olds with any decay experience.	30.2%	20%	37%	23.7%
Average number of decayed, missing due to dental decay and filled teeth among those with any decay experience.	4.8	3.2	2.6	3.5
Percentage of 5 year olds with obvious untreated dental decay.	28.8%	18.8%	36.1%	21.8%
Average number of decayed teeth among those with obvious untreated decay.	4.8	2.9	2.5	3.3

Tooth decay can start earlier than age 5. An oral health survey of 3 year olds was conducted in 2020 and the results are summarised in Table 6.2[2]. In 2020, 15.6% of 3 year olds in Furness, 8% of 3 year olds in Eden and 9.6% of 3 year olds in South Lakeland had experience of dentinal decay[2]. However, hospital admissions for dental caries in 0-5 year olds in Westmorland and Furness were significantly lower than the national average in 2020/21-22/23, with a crude rate of 43.3 per 100,000 compared to 178.8 per 100,000 in England[2].

Table 6.2: Key findings from the 2020 National Dental Epidemiology Programme for 3 year olds in Westmorland and Furness and England[2].

2020	Furness	Eden	South Lakeland	England
Percentage of 3 year olds with any decay experience.	15.6%	8%	9.6%	10.7%
Average number of decayed, missing due to dental decay and filled teeth among those with any decay experience.	2.7	1.6	3.3	2.9
Percentage of 3 year olds with obvious untreated dental decay.	14%	8%	8.4%	9.6%
Average number of decayed teeth among those with obvious untreated decay.	2.6	1.6	3.3	2.9

Healthy weight

Living with obesity is one of the leading preventable causes of morbidity and mortality both nationally and globally[3]. The worldwide prevalence of overweight and obesity has risen dramatically over recent decades, having almost tripled in adults and increased from 4% in children in 1975 to over 18% today[4]. The rate of increase in the prevalence of overweight and obesity in England has occurred more rapidly in both adults and children than in many other countries[5]. As a result, high body mass index (BMI) is now one of the leading risk factors attributable to age-standardised morbidity in England[6].

Children and young people affected by overweight and obesity are at increased risk of serious physical health complications, including hypertension, type two diabetes mellitus and non-alcoholic fatty liver disease, adverse effects on mental health, stigmatisation and bullying[7]. The likelihood of adverse health consequences increases into adulthood; current generations of children are living with excess weight from younger ages, increasing the risks of ill health and premature mortality[7]. Furthermore, children living with obesity are five times more likely to be living with obesity in adulthood than their peers[8]. Supporting children, young people and families to maintain a healthy weight is a key public health priority.

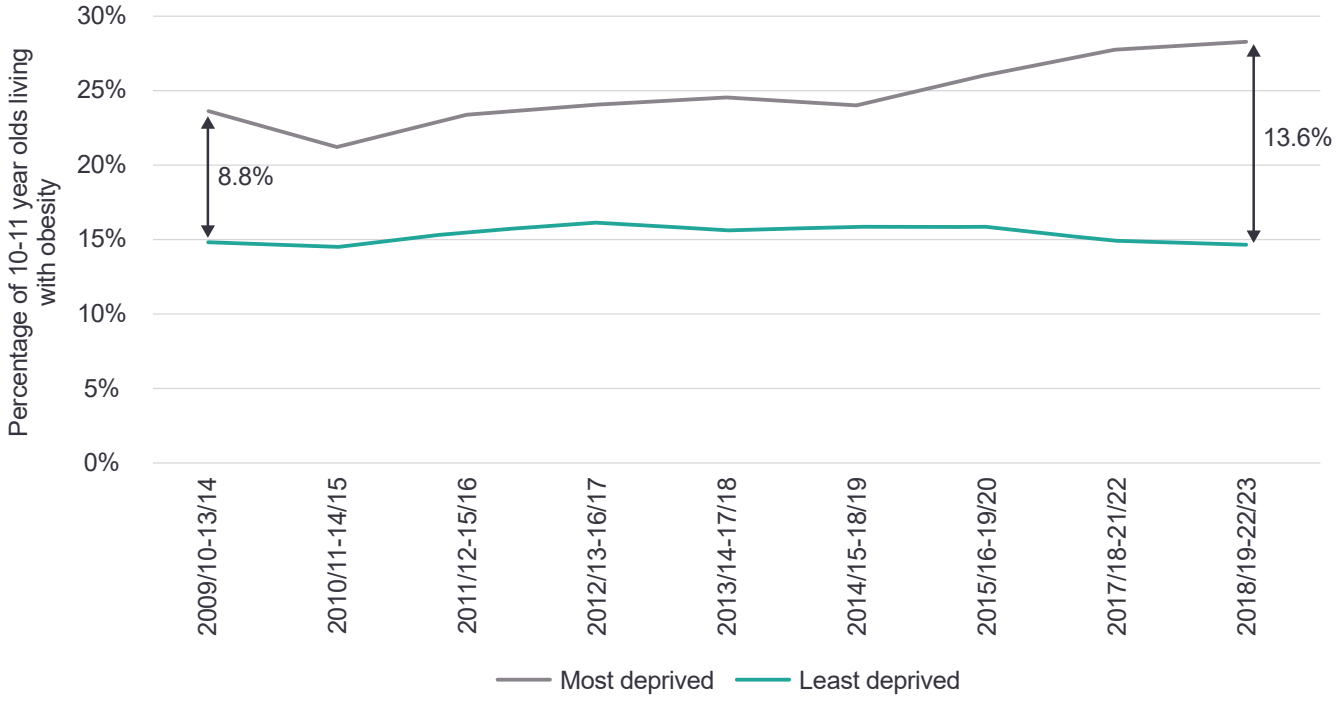
The National Child Measurement Programme collects data on children's height and weight at the start and end of primary school in England. Body mass index (BMI) in children is classed as overweight where it is on or above the 85th centile for their age and obese where it is on or above the 95th centile for their age. In Westmorland and Furness, just under 1 in every 4 4-5 year olds (23.4%) and over 1 in every 3 10-11 year olds (36%) are living with overweight or obesity[2].

Nationally, health inequalities in children and young people living with overweight and obesity are widening, and this is also seen in Westmorland and Furness[2]. Over the past decade, for 10-11 year olds living in the least deprived areas of Westmorland and Furness, the prevalence of obesity has remained stable from 14.8% in 2009/10-13/14 to 15.1% in 2018/19-22/23[2]. In contrast, over the same time period, the prevalence of obesity for 10-11 year olds living in the most deprived areas has increased from 23.6% to 29.6%[2]. Inequalities also exist within Westmorland and Furness at small area level[2]. Four small areas (MSOAs) in Furness have significantly more children living with overweight and obesity at either 4-5 years old or 10-11 years old than the national average[2]. In Ormsgill and Hindpool, over half of 10-11 year olds (51%) live with overweight or obesity[2].

Table 6.3: Prevalence of children living with underweight, healthy weight, overweight and obesity in Westmorland and Furness, North-West and England, 2023/24[2].

2023/24	Westmorland and Furness	North West	England
Reception prevalence of underweight (4-5 year olds)	0.5%	1%	1.2%
Reception prevalence of healthy weight (4-5 year olds)	75.8%	75.8%	76.8%
Reception prevalence of overweight (4-5 year olds)	13.9%	13.1%	12.4%
Reception prevalence of obesity (including severe obesity) (4-5 year olds)	9.8%	10.1%	9.6%
Year 6 prevalence of underweight (10-11 year olds)	1.2%	1.6%	1.7%
Year 6 prevalence of healthy weight (10-11 year olds)	63%	61.2%	62.5%
Year 6 prevalence of overweight (10-11 year olds)	15.1%	14%	13.8%
Year 6 prevalence of obesity (including severe obesity) (10-11 year olds)	20.7%	23.3%	22.1%

Figure 6.2: Proportion of 10-11 year olds living with obesity (including severe obesity) in Westmorland and Furness by local authority deprivation quintiles 1 and 5, 2009/10-13/14 to 2018/19-22/23[2].



Case study: Community Health, Wellbeing and Equity Partnerships

Local Government Reform (LGR) and the formation of Place Based Partnerships provided an opportunity to review and refresh local work in relation to health and wellbeing. Earlier local partnerships were accountable to the Cumbria Public Health Alliance to deliver the Joint Public Health Strategy. They were invaluable for sharing good practice, data and intelligence; and driving forward priority areas of work.

Post-LGR, the Public Health Alliance no longer exists and so new governance arrangements have been agreed. This is an exciting opportunity to reinvigorate local partnership working to influence health and wellbeing. The aim is the ensure a consistent approach so that the three local partnerships are fit for purpose, have appropriate representation, and focus on delivering positive outcomes for our communities. They will have joint accountability to the Health and Wellbeing Board and Locality Boards to enable action that will influence the wider determinants of health, health and care delivery, and address health inequalities. These new partnerships will also reflect lived experiences and be driven by local needs.

Initial workshops have explored the partnership roles in Eden, Furness and South Lakeland, to ensure that action is focussed at a neighbourhood level. The new partnerships will adopt a collaborative leadership role in reducing health inequalities through advocacy, data collection and community power, and by understanding and highlighting health inequalities for their respective local communities.

The three partnerships have been engaged in the development of the new Joint Local Health and Wellbeing Strategy for Westmorland and Furness; and are now forming task and finish groups to develop local action plans for implementation of the strategy's objectives. The first focus for the partnerships will be healthy weight.

Physical activity

Physical activity is a key contributor to maintaining health, wellbeing and happiness in children and young people. The UK Chief Medical Officers recommend that children and young people should take part in at least 60 minutes of moderate to vigorous physical activity every day; physical activity has specific benefits for children and young people including supporting the growth and development of muscle and bone health and improving motor development[9].

In 2022/23, under half (47.6%) of children and young people aged 5-16 in Westmorland and Furness were physically active for at least 60 minutes every day. This is similar to the national average (47%)[2]. The proportion of children and young people reporting enjoying their physical education (PE) lessons at school declines as they get older in Westmorland and Furness, and is 87% of primary school age pupils and falls to 64% of secondary school age pupils[10]. Young people are also less likely to take part in physical activity outside of school lessons as they get older; 81% of boys and 71% of girls in year 8 take part in physical activity outside of school lessons and this declines to 74% of boys and 63% of girls in year 10 children[10].

6.2 Emergency department attendances and hospital admissions

Emergency department attendances and hospital admissions for children aged 0-4

In 2022/23, whilst attendances at Accident and Emergency Departments were lower than the national average for under 1 year olds, emergency admissions to hospital for all causes for 1 year olds were 33% higher than the national average[2]. Admissions for two common conditions in under 1 year olds, gastroenteritis (195 per 10,000) and lower respiratory tract infection (1147.2 per 10,000) were also significantly higher than the national average[2]. Both gastroenteritis and lower respiratory tract infections are common illnesses that overall have low mortality. Monitoring changes in admission rates for these conditions over time will help to determine the success of treatment approaches outside of hospital, including support for parents in the management of illnesses at home and providing support and access to health advice and treatments in the community.

These trends continue for children aged 0-4[2]. Attendances at Accident and Emergency Departments for 0-4 year olds were lower than the national average in 2022/23, but emergency admissions to hospital were 45% higher than the national average[2]. Emergency admissions for gastroenteritis and lower respiratory tract infections for both 1 year olds and 2-4 year olds were significantly higher than the national average[2]. Admissions for gastroenteritis in 1 year olds were 2.8 times higher than the England average[2].

Table 6.4: Accident and Emergency department attendance rates and hospital admission rates for under 1 year olds, for Westmorland and Furness, North-West and England, 2022/23[2]. *Red boxes indicate significantly higher outcomes than the national average, orange boxes indicate outcomes that are similar to the national average and green boxes indicate significantly lower outcomes than the national average.*

2022/23	Westmorland and Furness	North West	England
A&E attendances (under 1 year)	811.4	1277.4	1132.3
Emergency admissions (under 1 year)	498	493.1	375.4
Emergency admissions for gastroenteritis (under 1 year)	195.9	167.8	113.2
Admissions for lower respiratory tract infections (under 1 year)	1147.2	1195	843.5

Table 6.5: Accident and Emergency department attendance rates and hospital admission rates for 0-4 year olds, for Westmorland and Furness, North-West and England, 2022/23[2]. *Red boxes indicate significantly higher outcomes than the national average, orange boxes indicate outcomes that are similar to the national average and green boxes indicate significantly lower outcomes than the national average.*

2022/23	Westmorland and Furness	North West	England
A&E attendances (0-4 years)	653.8	908	797.3
Emergency admissions (0-4 years)	228.9	209.7	158
Emergency admissions for gastroenteritis (aged 1 year)	228.6	126.3	82.7
Emergency admissions for gastroenteritis (aged 2-4 years)	95.3	73	49.5
Admissions for lower respiratory tract infections (aged 1 year)	285.7	232.9	179.7
Admissions for lower respiratory tract infections (aged 2-4 years)	52	51.9	42.9

Hospital admissions for children with long term conditions

Asthma, diabetes and epilepsy are the leading causes of emergency admissions to hospital for children and young people with long term health conditions, accounting for around 94% of emergency admissions[2]. Rates of emergency admissions to hospital for these conditions are monitored to determine how successful health services are in reducing avoidable admissions to hospital for children and young people with these conditions.

Asthma is the most common long-term health condition affecting children and young people in the UK and is a leading cause of emergency admissions to hospital[11]. Many emergency admissions to hospital which are caused by asthma in children are preventable with improved management of asthma and early interventions outside the hospital setting[11]. In 2022/23, emergency hospital admissions for 0-9 year olds for asthma in Westmorland and Furness were almost twice the national average[2]. Emergency admissions for 10-18 year olds, however, were similar to national levels[2].

Epilepsy is another long term health condition that can affect children and young people[12]. Optimal management of epilepsy can help to reduce emergency admissions to hospital and also improve overall health and wellbeing and quality of life[12]. In 2022/23, emergency hospital admissions for 0-9 year olds for epilepsy in Westmorland and Furness were significantly higher than the national average[2]. Emergency admissions for 10-18 year olds, however, were similar to national levels[2].

Emergency admissions to hospital for both 0-9 year olds and 10-18 year olds for diabetes in Westmorland and Furness were similar to the national average in 2022/23[2].

Table 6.6: Accident and Emergency department attendance rates and hospital admission rates for under 18 year olds and long-term conditions, for Westmorland and Furness, North-West and England, 2022/23[2]. *Red boxes indicate significantly higher outcomes than the national average, orange boxes indicate outcomes that are similar to the national average and green boxes indicate significantly lower outcomes than the national average.*

2022/23	Westmorland and Furness	North West	England
A&E attendances (under 18 years)	421.9	908	797.3
Emergency admissions (under 18 years)	92.6	209.7	158
Hospital admissions for asthma (0-9 years)	298.6	126.3	82.7
Hospital admissions for asthma (10-18 years)	70.1	73	49.5
Hospital admissions for epilepsy (0-9 years)	174.2	232.9	179.7
Hospital admissions for epilepsy (10-18 years)	70.1	51.9	42.9

Hospital admissions for injuries

Unintentional and deliberate injuries are a major cause of ill health and mortality for children and young people and disproportionately impact children with experience of socioeconomic deprivation[13]. Many injuries can be prevented through action to improve safety measures and advice, thereby reducing the risk of harm experienced by children and young people[13].

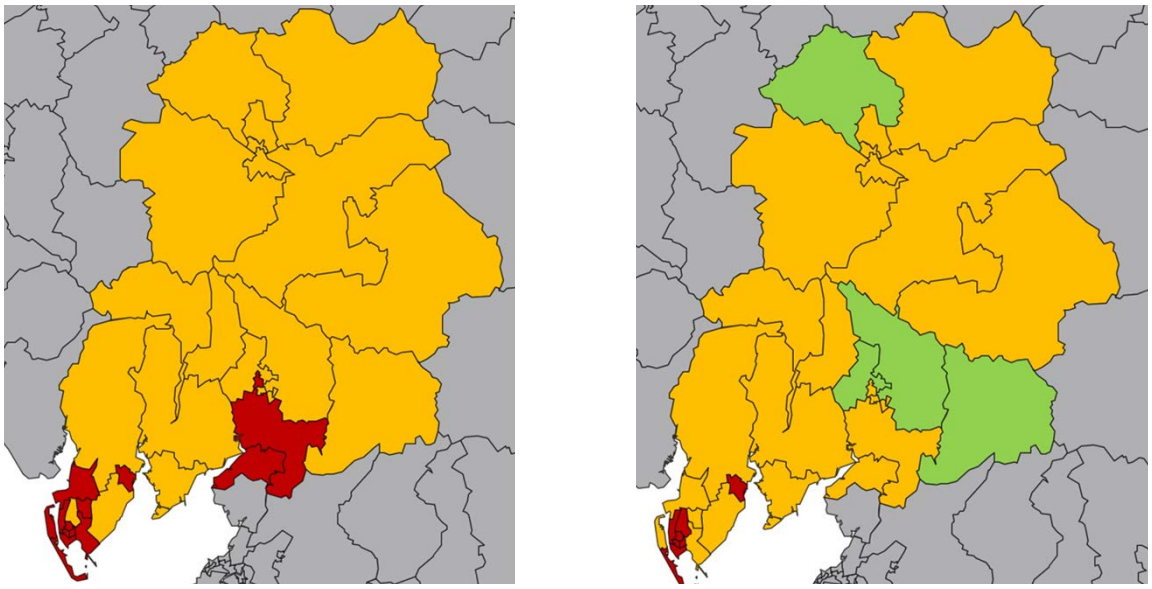
Rates of hospital admissions due to unintentional and deliberate injuries in children and young people were significantly higher in Westmorland and Furness than national rates for all age groups in 2022/23, although have improved for both 0-14 year olds and 15-24 year olds between 2021/22 and 2022/23[2].

Table 6.7: Hospital admission rates caused by unintentional and deliberate injuries in children and young people, for Westmorland and Furness, North-West and England, 2022/23[2]. *Red boxes indicate significantly higher outcomes than the national average, orange boxes indicate outcomes that are similar to the national average and green boxes indicate significantly lower outcomes than the national average.*

2022/23	Westmorland and Furness	North West	England
Hospital admissions caused by unintentional and deliberate injuries in children aged 0-4 years	123.6	120.5	92
Hospital admissions caused by unintentional and deliberate injuries in children aged 0-14 years	91.4	97.8	75.3
Hospital admissions caused by unintentional and deliberate injuries in young people aged 15-24 years	118.2	95.7	94.1

Rates of hospital admissions due to unintentional and deliberate injuries in children and young people at a small area level (MSOA) were most recently published for the years 2016/17-20/21[2]. Children aged 0-14 living in thirteen small areas (MSOAs) in Westmorland and Furness experienced significantly higher rates of hospital admissions due to injuries than the national average in this time period[2]. These areas are predominantly located in the districts of Furness and South Lakeland[2]. Young people aged 15-24 living in six small areas (MSOAs) in Furness experienced significantly higher ates of hospital admissions due to injuries than the national average during 2016/17-20/21[2]. In Ormsgill and Hindpool, the rate of emergency admissions for injuries in 15-24 year olds was over 3.5 times the national average[2].

Figure 6.3: Hospital admissions for accidental and unintentional injuries in 0-14 year olds (left) and 15-24 year olds (right), MSOAs in Westmorland and Furness, crude rate per 10,000, 2016/17-20/21[2]. *Red areas on the map indicate significantly higher rates than the national average, orange areas on the map indicate rates that are similar to the national average and green areas indicate significantly lower rates than the national average.*



6.3 Smoking, vaping, alcohol and substance misuse in young people

Smoking and vaping

Smoking is a leading cause of premature morbidity and mortality and, despite overall declining prevalence, remains the primary cause of preventable death in the UK (6). Most adult smokers begin smoking during adolescence[14]. Early onset of smoking is associated with higher mortality, lower quit rates and higher overall dependency[14]. In young people, addiction begins within four weeks of starting smoking[14]. Smoking negatively impacts lung function, exercise tolerance and growth in young people and increases the risk of developing respiratory disease such as asthma[14]. Reducing the prevalence of smoking in young people, and supporting young people to stop smoking, is a key public health priority.

The Children and Young People's Health Related Behaviour Questionnaire received over 2000 responses from primary and secondary school aged children across Westmorland and Furness in 2022[10]. 2% of secondary school age pupils from school years eight and ten reported smoking regularly[10]. 1 in 5 young people who reported smoking regularly said that they would like to stop smoking[10]. This is in-keeping with nationally collected data, which showed that in 2021, 1% of young people aged 11-15 smoked regularly, increasing to 3% of 15 year olds, and represents a reduction in smoking prevalence in young people over the past two decades[15].

Significantly more children and young people report vaping regularly. Of primary school children, 3% reported having tried vaping[10]. Of secondary school pupils, 33% reported having tried vaping, with 11% vaping regularly[10]. Vaping involves inhaling nicotine in vapour, which is generated by heating a liquid instead of smoke. Vaping can be used to help adults stop smoking but should not be used by children and young people[16]. There are growing concerns about the long-term impacts on health of vaping in children, which are as yet unknown[16]. Nicotine is also highly addictive and can lead to withdrawal symptoms[16]. National measures to reduce vaping in children and young people are being introduced, including the banning of disposable vapes.

Alcohol and substance misuse

Alcohol and substance misuse were the two leading risk factors for ill health and early death in 10-24 year olds in Cumbria in 2021 and have remained so for the past 30 years[6]. Regular alcohol consumption earlier in life is associated with an increased risk of alcohol-related harms, including dependence, in adulthood[17]. The Westmorland and Furness Children and Young People's Health Related Behaviour Questionnaire highlighted that over 1 in 5 of secondary school age pupils from years eight and ten had drunk alcohol in the two weeks preceding the survey[10].

A measure of alcohol-related harm in young people is the number of admissions to hospital for a condition that is wholly attributable to alcohol in under 18 year olds. Admission episodes for these alcohol-specific conditions in under 18s have been persistently significantly higher than the national average in Westmorland and Furness since 2012/13-14/15 and remained so in 2020/21-22/23 at a crude rate of 42.5 per 100,000 population (the crude rate for England is 26 per 100,000 population)[2]. There is no significant different between admission rates for males and females[2].

Figure 6.4: Admission episodes for alcohol-specific conditions in under 18s in Westmorland and Furness, North-West and England, 2012/13-14/15 to 2020/21-22/23, crude rate per 100,000[2].

The number of years lived with disability attributable to substance misuse in 10-24 year olds in Cumbria has increased by 30% since 1990[6]. Substance misuse is also the leading cause of years of life lost in 10-24 year olds, which have increased by 56% since 1990[6]. Harms associated with substance misuse in young people include risks to physical health from toxicity and infection, worsening mental health including an increased risk of depression and suicide, and adverse life experiences, with impacts on education, employment and contact with the criminal justice system[18].

Hospital admissions for substance misuse in young people (aged 15-24) in Westmorland and Furness have significantly fallen over the past decade and are now similar to the national average[2]. There is no significant different between hospital admission rates for substance misuse for males aged 15-24 compared to females (directly standardised rates 68.4 for males and 66.5 for females in Westmorland and Furness in 2020/21-22/23)[2]. Chapter seven will consider the impacts of smoking, alcohol and substance misuse on the health and wellbeing of adults in further detail.

Figure 6.5: Hospital admission episodes due to substance misuse in 15-24 year olds in Westmorland and Furness, North-West and England, 2012/13-14/15 to 2020/21-22/23, directly standardised rate per 100,000[2].

6.4 Mental health and emotional wellbeing

Research undertaken in 2023 found that about one in five children and young people aged 8-25 had a probable mental health disorder[19]. Nationally, the pandemic has adversely impacted on mental health and emotional wellbeing, with disproportionately greater impact on children and young people experiencing poverty[20].

Data from the 2022 Westmorland and Furness Health Related Behaviour Questionnaire shows that over four in ten primary school age pupils feel afraid of going to school because of bullying at least 'sometimes'; over eight in ten primary and secondary school age pupils feel worried 'quite a lot' or 'a lot'; and 37% of secondary school age pupils had low mental wellbeing scores (based on a standardised tool)[10].

Children and young people aged 10-24 living in Westmorland and Furness experience significantly higher rates of admission to hospital as a result of self-harm, than both the regional and national average (2022/23)[2]. Analysis by smaller age groups shows that hospital admissions related to self-harm are 1.6 times the national average for both young people aged 15-19 and young people aged 20-24[2]. There are also differences by gender; females aged 15-19 are almost 4 times more likely to be admitted as a result of self-harm than males in Westmorland and Furness[2].

The rate of hospital admissions for mental health conditions in children and young people aged under 18 was 76.7 per 100,000 population in 2022/23; this is similar to the national average (80.8 per 100,000 population)[2].

Figure 6.6: Hospital admissions as a result of self-harm in 10-24 year olds in Westmorland and Furness, North-West and England, 2011/12 to 2022/23, directly standardised rate per 100,000[2].

Table 6.8: Hospital admissions as a result of self-harm in 10-24 year olds in Westmorland and Furness by age group, North-West and England, 2022/23, directly standardised rate per 100,000 [2].

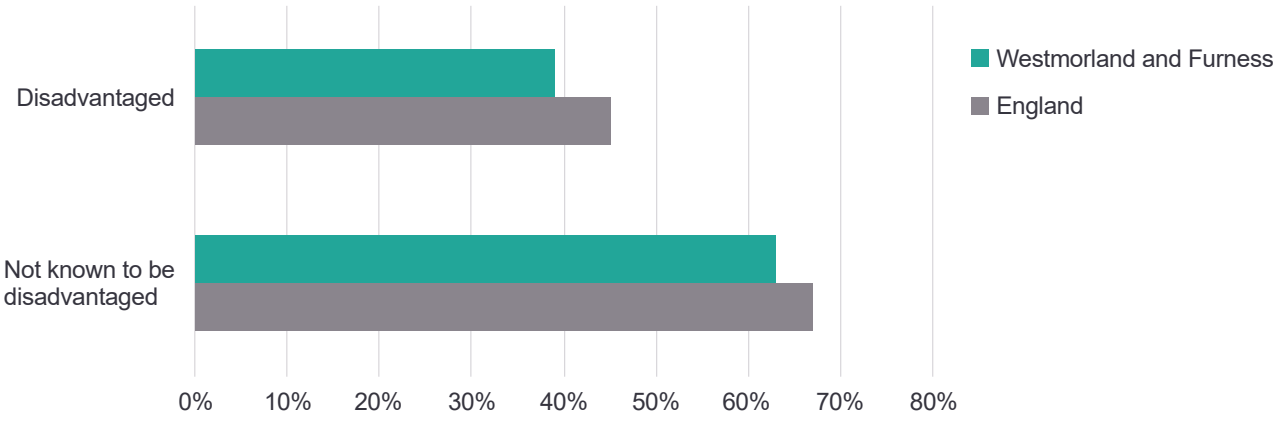
2022/23	Westmorland and Furness	North West	England
Hospital admissions as a result of self-harm in 10-14 year olds	343.3	368.2	251.2
Hospital admissions as a result of self-harm in 15-19 year olds	736.4	472.1	468.2
Hospital admissions as a result of self-harm in 20-24 year olds	398.7	212.5	244.4

6.5 Education, employment and training

Access to a good education and employment and training opportunities provide strong foundations for our health and wellbeing throughout life. Education shapes our lives: it is strongly associated with improved access to opportunities and employment, a reduced risk of experiencing poverty and reduced experience of health inequalities[21].

In Westmorland and Furness, the percentage of pupils meeting the expected standards in reading, writing and mathematics at the end of Key Stage 2 in 2023/24 was 58%, compared to 61% nationally[2]. Pupils are considered to be disadvantaged if they were registered as eligible for free school meals at any point in the last six years or were looked after by a local authority or have left local authority care through adoption, a special guardianship order, a residence order or a child arrangements order. For pupils who are known to be disadvantaged, 39% met the expected standards in reading, writing and mathematics at the end of Key Stage 2 in 2023/24, compared to 45% of disadvantaged pupils nationally[2]. This is a gap of 19% between outcomes for all pupils and disadvantaged pupils in Westmorland and Furness [2].

Figure 6.7: Percentage of pupils meeting the expected standard in reading, writing and mathematics at the end of Key Stage 2 in Westmorland and Furness and England, by disadvantaged status, 2023/24[2].



In Key Stage 4, the percentage of pupils who achieved a grade 4 or above in English and mathematics was 65.8%; this was similar to the national outcome at 65.4%[2]. For pupils who are known to be disadvantaged, this fell to 37.8%; this was lower than the national outcome for disadvantaged pupils at 43.7%[2]. Average Attainment 8 scores at the end of Key stage 4, which measures the average achievement of pupils in up to 8 qualifications, were also lower for pupils who were known to be disadvantaged, as seen in Figure 6.9[2]. In August 2024, 2.7% of 16-17 year olds in Westmorland and Furness were not in education, employment or training (NEET); the rate was higher in the Furness locality at 4.2%[2].

Figure 6.8: Percentage of pupils achieving Grade 4 or above in English and Mathematics GCSEs in Westmorland and Furness and England, by disadvantaged status, 2022/23[2].

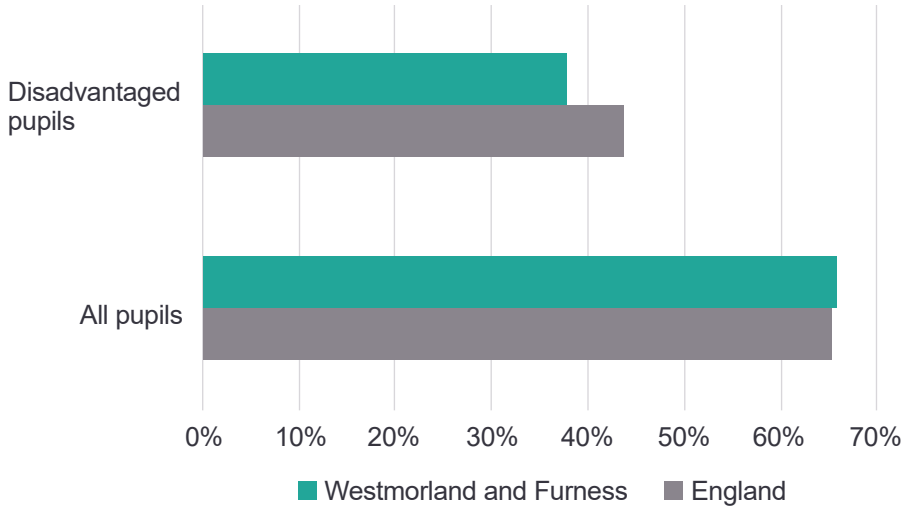
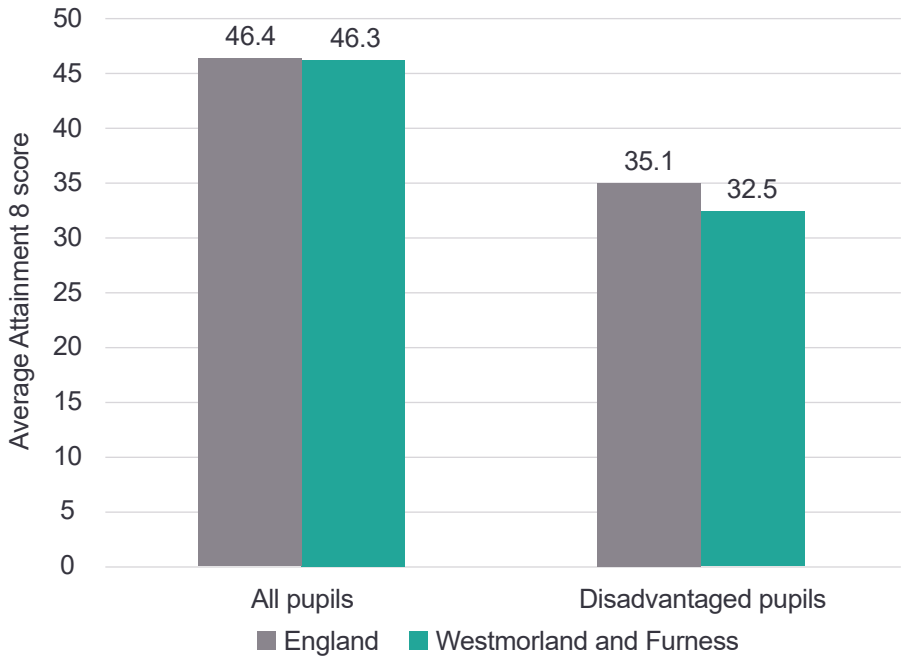


Figure 6.9: Average Attainment 8 scores at the end of Key Stage 4 in Westmorland and Furness and England, by disadvantaged status, 2022/23[2].



6.6 Summary

Poor health in childhood and adolescence influences future health outcomes, and therefore prevention and early intervention is key to reducing the risk of poor physical and mental health in adulthood.

Dental decay is largely preventable, but rates amongst 5-year-olds in South Lakeland and Furness are significantly higher than the national average. More than a third of pupils aged 10-11 are living with overweight or obesity, and prevalence is increasing for those living in the most deprived areas. More than half of children and young people in Westmorland and Furness are not meeting the daily physical activity guidelines, and enjoyment of PE lessons at school declines as children get older.

Hospital admissions for children and young people in Westmorland and Furness are significantly higher than the national average. Although the rate of young people smoking nationally has reduced, 1 in 10 secondary school pupils reported vaping regularly in Westmorland and Furness in 2022. Admission rates for alcohol-specific conditions for under 18s are significantly higher than the national average, although hospital admissions for substance misuse in young people aged 15-24 in Westmorland and Furness have significantly fallen over the last decade and are now similar to the national average. Hospital admissions as a result of self-harm for 15-24 years are significantly higher than the national average.

The percentage of pupils in Westmorland and Furness meeting the expected standards in reading, writing and mathematics at the end of Key Stage 2, and the percentage of pupils achieving a grade 4 or above in English and Mathematics at Key Stage 4, was similar to the national average. However, outcomes for pupils who are known to be disadvantaged are lower than the national averages.

6.7 Recommendations

Investing in services and support for children and young people needs to be given greater priority if we are to improve health and wellbeing in later life. This includes ensuring children and young people, and families, have access to a wide range of activities which support resilience, health and wellbeing, and reflect the needs and aspirations of the children and young people of Westmorland and Furness.

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7. Living Well

7.1 The leading causes of mortality are associated with a number of shared risk factors which can be prevented

Chapter two of this report highlighted that our residents are spending more of their lives in ill health and that people living in our most disadvantaged areas are dying earlier from preventable illnesses. Mortality rates are a fundamental method of assessing the health status of a population, encompassing the prevalence of risk factors predisposing to ill health, the prevalence of ill health itself and how effectively ill health can be treated.

Table 7.1: Standardised mortality ratios (SMRs) for Furness, Eden and South Lakeland compared to England, 2016-2020[1]. *Red boxes indicate significantly higher SMRs than the national average, orange boxes indicate SMRs that are similar to the national average and green boxes indicate significantly lower SMRs than the national average.*

Indicator	England	Furness	Eden	South Lakeland
Deaths from all causes, all ages, 2016-2020	100.0	119.1	81.3	88.6
Deaths from all cancer, all ages, 2016-2020	100.0	110.1	83.3	85.0
Deaths from circulatory disease, all ages, 2016-2020	100.0	120.0	92.4	93.7
Deaths from coronary heart disease, all ages, 2016-2020	100.0	117.0	95.4	85.8
Deaths from stroke, all ages, 2016-2020	100.0	119.8	92.2	118.0
Deaths from respiratory diseases, all ages, 2016-2020	100.0	118.2	71.7	71.8

Table 7.1 shows standardized mortality ratios (SMRs) for Furness, Eden and South Lakeland for all causes and a number of common causes of ill health (1). These SMRs compare the number of deaths in the defined geographical area (Furness, Eden or South Lakeland) between 2016-2020, to the number of deaths that might be expected if that area had the same rates of death as the population of England as a whole[1].

Furness has an SMR of 119 for deaths for all causes[1]. This indicates that there were 19% more deaths than expected compared to England[1]. Eden has an SMR of 81 for deaths from all causes, indicating that there were 19% fewer deaths than expected compared to England[1]. South Lakeland has an SMR of 88.6, indicating that there were 11.4% fewer deaths than expected compared to England[1]. These trends are similar for deaths from cancer, cardiovascular disease (including deaths from coronary heart disease such as heart attacks and deaths from strokes) and deaths from respiratory disease[1]. SMRs for deaths from all causes listed in Furness were significantly more than expected compared to England, whereas SMRs for deaths from all causes listed in Eden were either similar to or significantly fewer than expected compared to England[1]. South Lakeland data indicates that there were 18% more deaths from stroke than expected in 2016-2020, with significantly fewer deaths than expected from the other causes listed[1].

Differences in mortality rates between populations sadly reflect health inequalities between different population groups, as described in chapter three. Differences in SMRs can also be seen at smaller geographical levels within Westmorland and Furness[1]. Tables 7.2-7.4 show the electoral wards (pre-2023 boundaries) with the highest and lowest SMRs for deaths from all causes, deaths from cancer and deaths from circulatory disease (including heart attacks and strokes) in people aged under 75[1].

The leading causes of deaths in Cumbria are cardiovascular disease (age-standardised rate 84.6 deaths per 100,000 population), cancer (age-standardised rate 62.2 deaths per 100,000 population) and chronic respiratory disease (age-standardised rate 15.2 deaths per 100,000 population)[2]. These have remained the leading causes of death in Cumbria for the last thirty years and mirror the leading causes of death in England[2]. These causes of death share a number of potentially preventable risk factors, including smoking, living with excess weight, high fasting blood sugar (plasma glucose) levels which are associated with diabetes, and high alcohol use[2]. Whilst the burden of disease attributable to smoking, high blood pressure, high alcohol use and high cholesterol has fallen over the past decade, the burden of disease attributable to living with excess weight, having high fasting blood sugar levels and substance misuse has risen (Figure 7.1)[2].

Figure 7.1: Disability-adjusted life years (DALYs) per 100,000 population attributable to health risk factors in Cumbria, age-standardised, 2021 compared to 2011[2].

Source: Institute for Health Metrics and Evaluation, Global Burden of Disease Compare Tool.

The leading health risk factors in Cumbria in 2021		% Change 2011-2021	
1/	Smoking	-17.7%	↓
2/	High body mass index (BMI)	+11.9%	↑
3/	High fasting plasma glucose	+27.5%	↑
4/	High blood pressure	-12.3%	↓
5/	High alcohol use	-1.2%	↓
6/	Substance misuse	+12.7%	↑
7/	High low-density lipoprotein cholesterol	-12.6%	↓

Table 7.2: Electoral wards[i] with the lowest and highest standardised mortality ratios (SMRs) for deaths from all causes in under 75 year olds in Westmorland and Furness, 2016-2020[1]. *Red boxes indicate significantly higher SMRs than the national average, orange boxes indicate SMRs that are similar to the national average and green boxes indicate significantly lower SMRs than the national average.*

Rank	Area (electoral wards)	SMR	Rank	Area (electoral wards)	SMR
1	Central	245.6	67	Brough	48.0
2	Hindpool	222.5	68	Hartside	46.7
3	Barrow Island	190.4	69	Crosby Ravensworth	45.5
4	Penrith Pategill	173.2	70	Dacre	35.5
5	Risedale	156.1	71	Ullswater	32.7

Table 7.3: Electoral wards[i] with the lowest and highest standardised mortality ratios (SMRs) for deaths from cancer in under 75 year olds in Westmorland and Furness, 2016-2020[1]. *Red boxes indicate significantly higher SMRs than the national average, orange boxes indicate SMRs that are similar to the national average and green boxes indicate significantly lower SMRs than the national average.*

Rank	Area (electoral wards)	SMR	Rank	Area (electoral wards)	SMR
1	Central	173.8	67	Hartside	41.0
2	Penrith Pategill	142.6	68	Dacre	40.0
3	Barrow Island	137.9	69	Skelton	38.0
4	Orton with Tebay	123.3	70	Crosby Ravensworth	37.3
5	Kendal West	122.1	71	Ullswater	36.2

Table 7.4: Electoral wards with the lowest and highest standardised mortality ratios (SMRs) for deaths from circulatory disease in under 75 year olds in Westmorland and Furness, 2016-2020[1]. *Red boxes indicate significantly higher SMRs than the national average, orange boxes indicate SMRs that are similar to the national average and green boxes indicate significantly lower SMRs than the national average.*

Rank	Area (electoral wards)	SMR	Rank	Area (electoral wards)	SMR
1	Hindpool	272.6	66	Eamont	43.4
2	Central	225.8	67	Dacre	29.2
3	Penrith Pategill	219.7	68	Langwathby	29.0
4	Appleby (Appleby)	175.7	69	Kendal South and Natland	20.5
5	Barrow Island	166.0	70	Ullswater	16.6
6	Risedale	156.2	71	Hartside	15.1

[i]This refers to the geographical areas of pre-2023 electoral wards, as described earlier in the report.

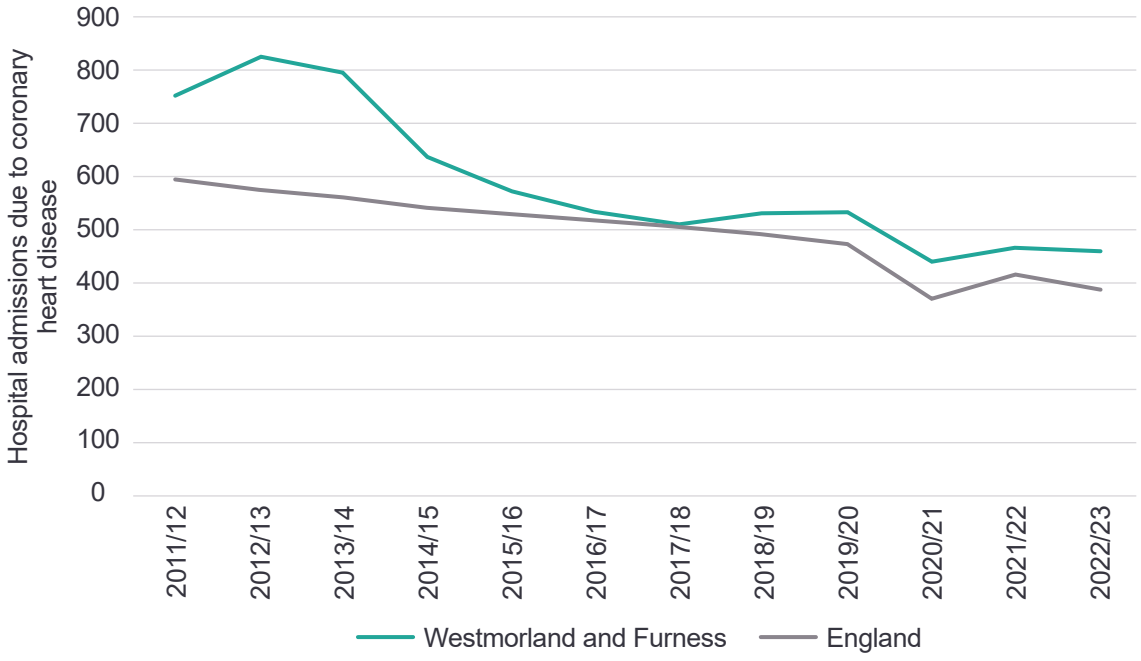
Cardiovascular disease

Cardiovascular disease (CVD) is the leading cause of death in Cumbria and has been for over thirty years[2]. Cardiovascular diseases are health conditions which affect the heart or blood vessels and include coronary heart disease (such as angina and heart attacks) and strokes. Cardiovascular diseases share a number of a risk factors, including health related practices such as smoking, alcohol use, living with overweight or obesity and physical activity, and conditions which predispose to CVD, including having high cholesterol, high blood pressure and atrial fibrillation (having an irregular and often fast heartbeat).

Through action to modify these risk factors, much cardiovascular disease can be prevented. Efforts need to focus on primary prevention, to identify and reduce health-related practices associated with CVD, secondary prevention, to identify and treat early pathological changes which can predispose to CVD, such as those due to high blood pressure and high cholesterol, and tertiary prevention, to support those who have CVD to live with an improved quality of life and slow the progression of recurrence and future disease[3].

Hospital admissions due to coronary heart disease, such as angina and heart attacks, in 2022/23 were significantly higher in Westmorland and Furness than the national average (459.1 per 100,000 population in Westmorland and Furness compared to 387.1 per 100,000 population in England, Figure 7.2)[1]. This includes both emergency care for acute events such as heart attacks and elective treatment for people with established coronary heart disease.

Figure 7.2: Hospital admissions due to coronary heart disease in Westmorland and Furness and England, directly standardised rate per 100,000 population, 2011/12 to 2022/23[1].



Hospital admissions due to heart failure in Westmorland and Furness (providing both emergency care and planned elective care) in 2022/23 were significantly lower than the national average[1]. Advanced heart failure can be described as the final common pathway for almost all types of cardiovascular disease and around 4 out of every 10 people with heart failure will die within a year of diagnosis[4]. Evidence shows that most people prefer to die at home or in their usual place of residence[5]. However, the proportion of people who died at home or in their usual place of residence from heart failure in 2021-22 was significantly lower than the national average (53.1% in Westmorland and Furness compared to 59.7% in England)[1].

In 2022/23, hospital admissions due to stroke in Westmorland and Furness were similar to the national average (173.5 per 100,000 population compared to 168.4 per 100,000 population in England)[1]. Whilst the mortality rate from stroke in under 75 year olds in 2020-22 in Westmorland and Furness was similar to the national average, the mortality rate from stroke for over 74 year olds was significantly higher than the national rate (520.2 per 100,000 population compared to 430.7 per 100,000 population in England)[1].

Figure 7.3: Over 74 mortality rate from stroke in Westmorland and Furness and England, directly standardised rate per 100,000 population, 2011-13 to 2020-22[1].

Accidents

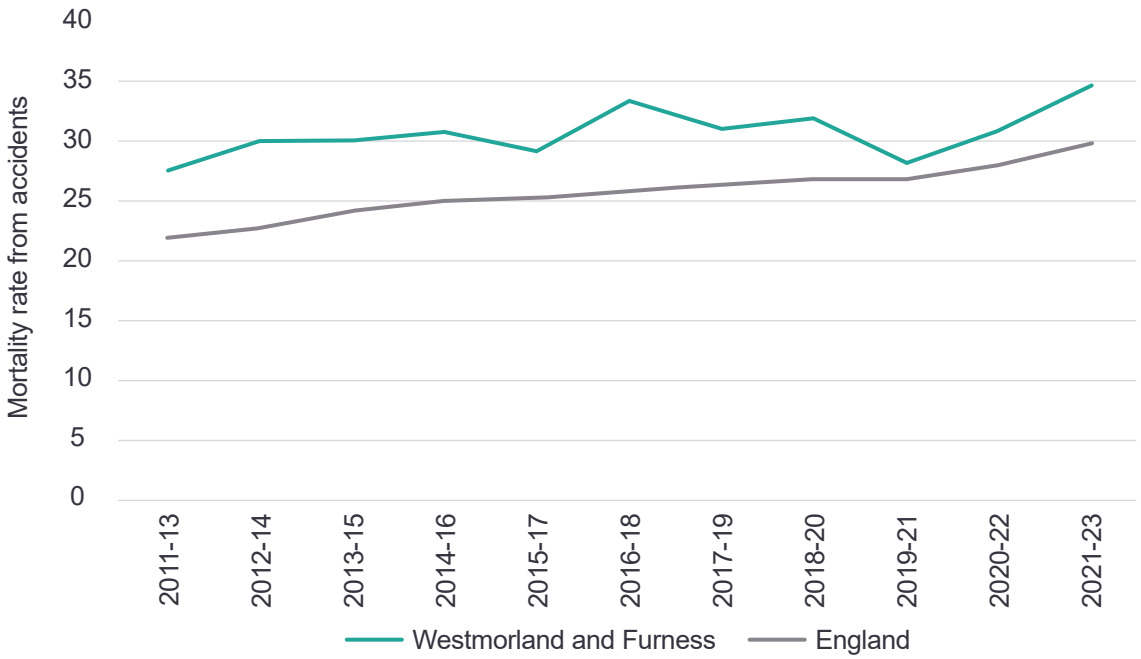
The mortality rate from accidents for all ages was significantly higher in Westmorland and Furness in 2021-23 than the national rate, at 34.5 per 100,000 population compared to 29.7 per 100,000 population, as seen in Table 7.5[1]. The mortality rate from accidents in Westmorland and Furness has remained higher than the national average for a number of years, as seen in Figure 7.4[1].

Table 7.5: Mortality rates from accidents for all ages and under 75 year olds, by gender, in Westmorland and Furness, North-West and England, directly standardised rate per 100,000 population, 2021-2023[1]. *Red boxes indicate significantly higher SMRs than the national average, orange boxes indicate SMRs that are similar to the national average and green boxes indicate significantly lower SMRs than the national average.*

2021-23	Westmorland and Furness	North West	England
Mortality rate from accidents, all ages (persons)	34.5	37.0	29.7
Mortality rate from accidents, all ages (males)	45.0	48.2	39.0
Mortality rate from accidents, all ages (females)	24.7	27.2	21.6
Under 75 mortality rate from accidents (persons)	21.2	21.3	15.7
Under 75 mortality rate from accidents (males)	30.9	29.9	22.5
Under 75 mortality rate from accidents (females)	11.5	13.0	9.2

Mortality rates from accidents can be further examined by age and gender. Within Westmorland and Furness, it is the mortality rate from accidents in males under 75 which is significantly higher than the national rate (30.9 per 100,000 population compared to 22.5 per 100,000 population)[1]. Mortality rates from accidents include deaths due to transport accidents, other causes of accidental injury such as falls and drowning, and accidental poisoning. It does not include deaths caused by intentional self-harm or assault.

Figure 7.4: Mortality rate from accidents for all ages (persons), in Westmorland and Furness, North-West and England, directly standardised rate per 100,000 population, 2011-13 to 2021-23[1].



7.2 The prevalence of the leading preventable risk factors for ill health in Westmorland and Furness

Smoking

Smoking is one of the greatest threats to public health worldwide and is a causative agent in sixteen types of cancer, chronic respiratory diseases and circulatory diseases including heart disease and stroke[6]. There is an established social gradient in smoking in the UK; children and young people are twice as likely to be regular smokers if they are from the most deprived areas[6]. Furthermore, the gap between smoking prevalence in the most deprived and least deprived areas is persisting as the overall prevalence of smoking falls[6]. As smoking is so harmful to health, this sadly translates into inequalities in the risk of developing smoking-related disease or death[6].

Table 7.6: Smoking prevalence in adults in Furness, Eden and South Lakeland compared to England, 2022 and 2022/23[1]. *Red boxes indicate significantly higher SMRs than the national average, orange boxes indicate SMRs that are similar to the national average and green boxes indicate significantly lower SMRs than the national average.*

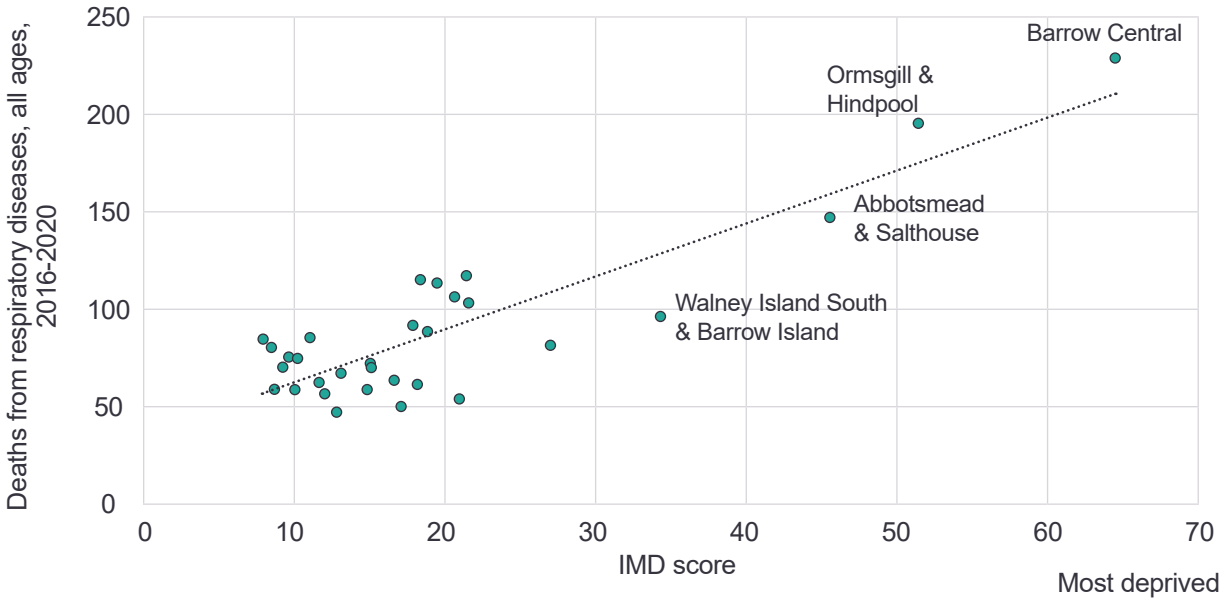
Smoking prevalence	Furness	Eden	South Lakeland	England
Adults (aged 18 and over) – current smokers, 2022	21%	11%	10.4%	12.7%
Adults in routine and manual occupations (aged 18-64) – current smokers, 2022	34.3%	19.2%	19.3%	22.5%
Adults with a long term mental health condition (aged 18 and over) – current smokers, 2022/23	28.3%	20.1%	21.3%	25.1%
Smoking status at the time of delivery, 2022/23	10.4%	10%	10.5%	8.8%

In 2022, 21% of adults in Furness, 11% of adults in Eden and 10.4% of adults in South Lakeland were current smokers, compared to 12.7% in England[1]. Smoking rates are significantly higher in adults who work in routine and manual occupations and adults with long term mental health conditions[1]. In Furness, over 1 in 3 adults (34.3%) who works in a routine and manual occupation and just under 3 in 10 adults (28.3%) with a long term health mental health condition smoke[1]. Smoking rates at the time of delivery in 2022/23 were 10.4% of mothers in Furness, 10% of mothers in Eden and 10.5% of mothers in South Lakeland, compared to 8.8% in England[1].

Overall, the mortality rates from respiratory disease and chronic obstructive pulmonary disease (COPD) in Westmorland and Furness are significantly lower than the national rates (the mortality rate from respiratory diseases for all ages (persons, 1 year range) in 2023 was 99.7 per 100,000 population compared to 117.8 per 100,000 in England; the mortality rate from COPD for all ages (persons, 1 year range) in 2021-23 was 38.3 per 100,000 population compared to 43.9 per 100,000 in England)[1].

However, standardised mortality ratios (SMRs) for deaths from respiratory diseases at smaller area level (MSOA) show there is significant variation across Westmorland and Furness[1]. The three MSOAs that experience the highest deprivation levels (Barrow Central; Ormsgill and Hindpool; Abbotsmead and Salthouse) have significantly more deaths than would be expected when compared to England (Figure 7.5)[1].

Figure 7.5: Deaths from respiratory diseases in 2016-2020, all ages, standardised mortality ratios for MSOAs in Westmorland and Furness by Index of Multiple Deprivation score[1].



Case study: Allen Carr's Easyway

In 2023, Westmorland and Furness Council commissioned Allen Carr's Easyway to Stop Smoking Method, which uses clinically proven cognitive behavioural therapy techniques delivered through online seminars or videos to support people to stop smoking. Allen Carr's Easyway is endorsed by the National Institute of Health and Clinical Excellence as a drug free way of stopping smoking.

The initial pilot was focussed in Furness, with 68% of participants from lower socio-economic backgrounds. The social media recruitment for the programme was exceptionally successful and all the available places were filled within a few weeks. Over 50% of participants had stopped smoking after 4 weeks, with over 40% of participants continuing not to smoke at 12 weeks.

Feedback:

"1 week in - Do it if you can, just put the code in, I did the seminar and it's amazing."

"4 weeks in - I wanted to let you know that I am doing brilliantly. I am a happy non smoker now. I didn't think I would be able to do it after smoking for 38 years which is all of my adult life. I am amazed that I don't even think about smoking majority of the time. My partner smokes and it doesn't bother me and I've been out on a couple of occasions and I wasn't bothered then either. Thank you so much for this opportunity."

"3 months in - I am still a very happy non smoker. This has done wonders for me and also friends and family whom I told about it. I think the Allen Carr Easyway should be the NHS first remedy for anyone wanting to give up smoking.

"4 weeks in - I'm not smoking, 50+ years smoking I think the Allen Carr method is virtually miraculous. So, I'll carry on, there's no chance of me smoking again."

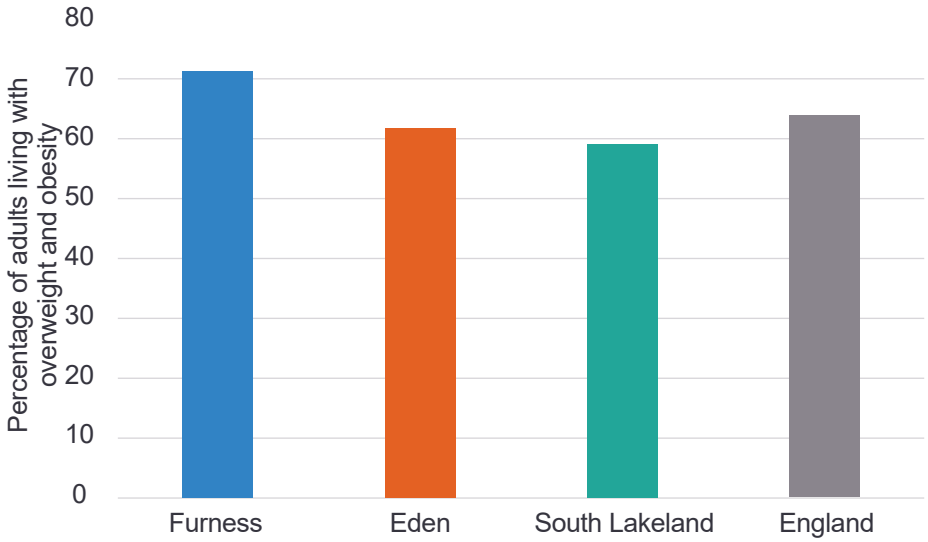
"2 months in - Just in shock... after up to 60 a day, I have not had a ciggy since doing day course online. My family in shock..shock..money I have saved is amazing . Cough has gone..the only way I can repay them is by telling everyone this can and does work ...get your head in the right place first ..believe in it ..want it..miracles do happen

"3 months in - It certainly worked for me I haven't even missed them after 50 years of smoking. Thank you so much."

Healthy weight

Living with obesity is one of the leading preventable causes of morbidity and mortality[2]. In 2022/23, just over 6 out of every 10 adults (62.2%) in Westmorland and Furness lived with overweight or obesity (Figure 7.6)[1]. This is similar to the national prevalence of 64%[1].

Figure 7.6: Percentage of adults living with overweight and obesity in 2022/23 in Furness, Eden and South Lakeland compared to England[1].

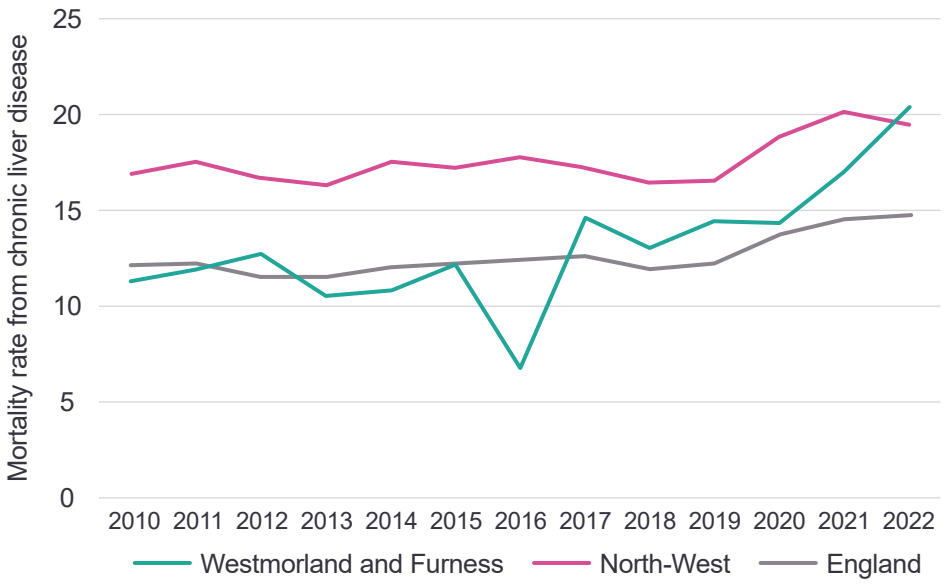


Alcohol use

Harmful alcohol use can be defined as levels of alcohol consumption that directly result in adverse health and social outcomes, including cancer, liver disease, cardiovascular disease, alcohol use disorders and mental health conditions[7]. Areas of higher socioeconomic deprivation in England experience greater levels of alcohol-related harms, independent of the amount of alcohol that is consumed at a population level[8]. The underlying mechanisms of this 'alcohol harm paradox' are thought to be multifactorial and are associated with the social determinants of health, or the building blocks of health and wellbeing[8], discussed in chapter three.

Deaths from chronic liver disease in England are rising; this is in contrast to what is seen in many other countries in Europe, where deaths from liver disease are falling[2]. Alcohol consumption is the most common cause of chronic liver disease in England, followed by living with overweight and obesity leading to fat accumulation in the liver (NAFLD) and chronic viral hepatitis infections[2]. In 2022, mortality from chronic liver disease in Westmorland and Furness was significantly higher than the national mortality rate (20.3 per 100,000 population compared to 14.7 per 100,000 population), as seen in Figure 7.7[1]. Mortality from chronic liver disease in Westmorland and Furness has significantly increased over time, when 2022 rates are compared to 2016 rates[1]. However, the alcohol-related mortality rates and alcohol-specific mortality rates in Westmorland and Furness were similar to the national average in 2022[1].

Figure 7.7: Mortality from chronic liver disease, all ages (1 year range) in Westmorland and Furness, North-West and England, directly standardised rate per 100,000 population, 2010-2022[1].



Potential years of life lost (PYLL) provides a measure of premature mortality, by estimating the number of years a person would have lived if they had not died prematurely. The potential years of life lost due to alcohol-related conditions in females in Westmorland and Furness is significantly higher than the national average (857 per 100,000 population compared to 536 per 100,000 population in England), but is similar to the national average for males (Figure 7.8)[1].

Figure 7.8: Potential years of life lost due to alcohol-related conditions in Westmorland and Furness, North-West and England, directly standardised rate per 100,000 population, 2016 to 2022. Top graph: males. Bottom graph: females[1].

As alcohol related deaths often occur at younger ages, alcohol related harms can also be quantified using potential working years of life lost (PWYLL), which estimates the number of working years are lost each year due to premature death as a result of alcohol. The potential working years of life lost due to alcohol related conditions are significantly higher for both males and females in Westmorland and Furness than in England (653 per 100,000 population for males compared to 484 per 100,000 population in England in 2022; 397 per 100,000 population for females compared to 202 per 100,000 population in England in 2022) (Figure 7.9)[1].

Figure 7.9: Potential working years of life lost due to alcohol-related conditions in Westmorland and Furness, North-West and England, directly standardised rate per 100,000 population, 2016 to 2022. Top graph: males. Bottom graph: females.[1]

7.3 Health checks and screening

NHS Health Checks

NHS Health Checks programme are offered to people aged between 40 and 74 and aim to help prevent cardiovascular disease, including heart disease, stroke, diabetes and kidney disease. People who are eligible are invited every 5 years to receive support in managing their risk of cardiovascular disease. Significantly fewer people in Westmorland and Furness were offered and received an NHS Health Check between 2019/20 and 2023/24, when compared to both the regional and national levels (Table 7.7)[1].

Table 7.7: Offers and uptake of NHS health checks in Westmorland and Furness, North-West and England, 2019/20 - 2023/24[1]. *Red boxes indicate significantly higher SMRs than the national average, orange boxes indicate SMRs that are similar to the national average and green boxes indicate significantly lower SMRs than the national average.*

2019/20 - 23/24	Westmorland and Furness	North West	England
Cumulative percentage of the eligible population (aged 40-74) offered an NHS health check	20.3%	95.5%	69.1%
Cumulative percentage of the eligible population (aged 40-74) offered an NHS health check who received an NHS health check	41.4%	34.3%	40.6%
Cumulative percentage of the eligible population (aged 40-74) who received an NHS health check	8.3%	32.7%	28.1%

Screening

Screening involves the early identification of people who are at risk of a particular health problem, to allow early treatment and improve outcomes. Adults are offered screening for breast, cervical and bowel cancer at different ages throughout their lifetimes and men aged 65 are offered screening for abdominal aortic aneurysms. Screening coverage for Westmorland and Furness is shown in table 7.8; overall, screening coverage is better in Westmorland and Furness than the England coverage rates[1].

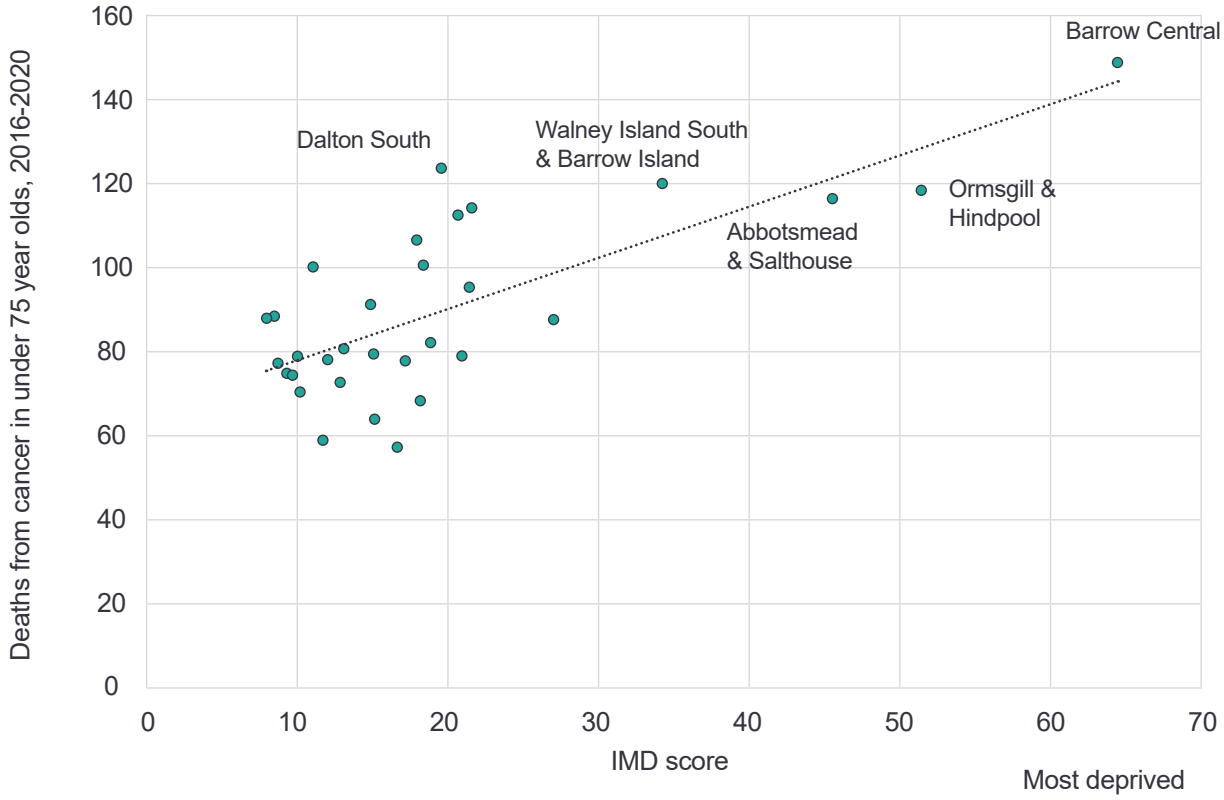
Table 7.8: Cancer screening coverage for breast cancer, cervical cancer and bowel cancer in 2023 and abdominal aortic aneurysm screening coverage in 2022/23 in Westmorland and Furness, North-West and England[1]. *Red boxes indicate significantly higher SMRs than the national average, orange boxes indicate SMRs that are similar to the national average and green boxes indicate significantly lower SMRs than the national average.*

2022-23	Westmorland and Furness	North West	England
Cancer screening coverage: breast cancer, 2023	73.2%	65.8%	66.2%
Cancer screening coverage: cervical cancer, aged 25-40, 2023	73%	66.9%	65.8%
Cancer screening coverage: cervical cancer, aged 50-64, 2023	77.8%	73.5%	74.4%
Cancer screening coverage: bowel cancer, 2023	78.1%	70.6%	72.0%
Abdominal aortic aneurysm screening coverage, 2022/23	81.9%	70.2%	78.3%

There is notable variation between screening coverage at a lower geographical level[1]. At GP practice level in Westmorland and Furness in 2022/23 , 3 year breast cancer screening coverage varied between 57.9% and 77.6%; 3.5 year cervical screening coverage for women aged 25 to 49 varied between 66.2% and 84.5%; 5.5 year cervical screening coverage for women aged 50 to 64 varied between 66.2% and 89.6%; and bowel cancer screening coverage varied between 67.5% and 82.6%[1]. Improvements to cancer screening coverage increase the likelihood that early changes can be detected and treated, reducing the risk of cancer developing later on and improving treatment outcomes[9].

Standardised mortality ratios (SMRs) for deaths from cancer in under 75 year olds at smaller area level (MSOA) show there is significant variation across Westmorland and Furness[1]. The four MSOAs that experience the highest deprivation levels (Barrow Central; Ormsgill and Hindpool; Abbotsmead and Salthouse; Walney Island South and Barrow Island) have significantly more deaths than would be expected when compared to England (Figure 7.10)[1].

Figure 7.10: Deaths from cancer in under 75 year olds in 2016-2020, standardised mortality ratios for MSOAs in Westmorland and Furness by Index of Multiple Deprivation score[1].



7.4 Substance misuse

Drug use disorders were the leading cause of death for people aged 15-49 in Cumbria in 2021 and have significantly increased over past decade (Table 7.9)[1].

Table 7.9: Rates of death from drug misuse in Westmorland and Furness, North-West and England, 2020-22[1]. *Red boxes indicate significantly higher SMRs than the national average, orange boxes indicate SMRs that are similar to the national average and green boxes indicate significantly lower SMRs than the national average.*

2020-22	Westmorland and Furness	North West	England
Rate of death from drug misuse (persons)	9.8	7.7	5.2
Rate of death from drug misuse (males)	13.3	10.8	7.6
Rate of death from drug misuse (females)	6.3	4.6	2.9

In 2020-22, the rate of deaths from drug misuse for both males and females was significantly higher in Westmorland and Furness than both the North-West overall rate and the England rate and has been increasing over time (Figure 7.11)[1].

Figure 7.11: Deaths from drug misuse in Westmorland and Furness, North-West and England, directly standardised rate per 100,000 population, 2010-12 to 2020-22[1].

7.5 Mental health and emotional wellbeing

Mental health can be described as "a state of mental well-being that enables people to cope with the stresses of life, realise their abilities, learn well and work well, and contribute to their community" (10). Good mental health and emotional wellbeing is as important as our physical health and is a fundamental component of our overall health and wellbeing throughout the life course. Recent community engagement conducted by the Public Health Team on community health and wellbeing priorities demonstrated that action to improve mental health and emotional wellbeing throughout the life course is a key local priority[11]. National data shows that one in every four people will be impacted by a mental health problem during their lifetime[12].

Mental health problems are both a cause and a consequence of health inequalities and this is evident within Westmorland and Furness. Self-reported measures of life satisfaction, happiness and anxiety scores are higher than the national average in Eden and South Lakeland but have worsened in Furness over the past decade and remain below the national average (Table 7.10)[1].

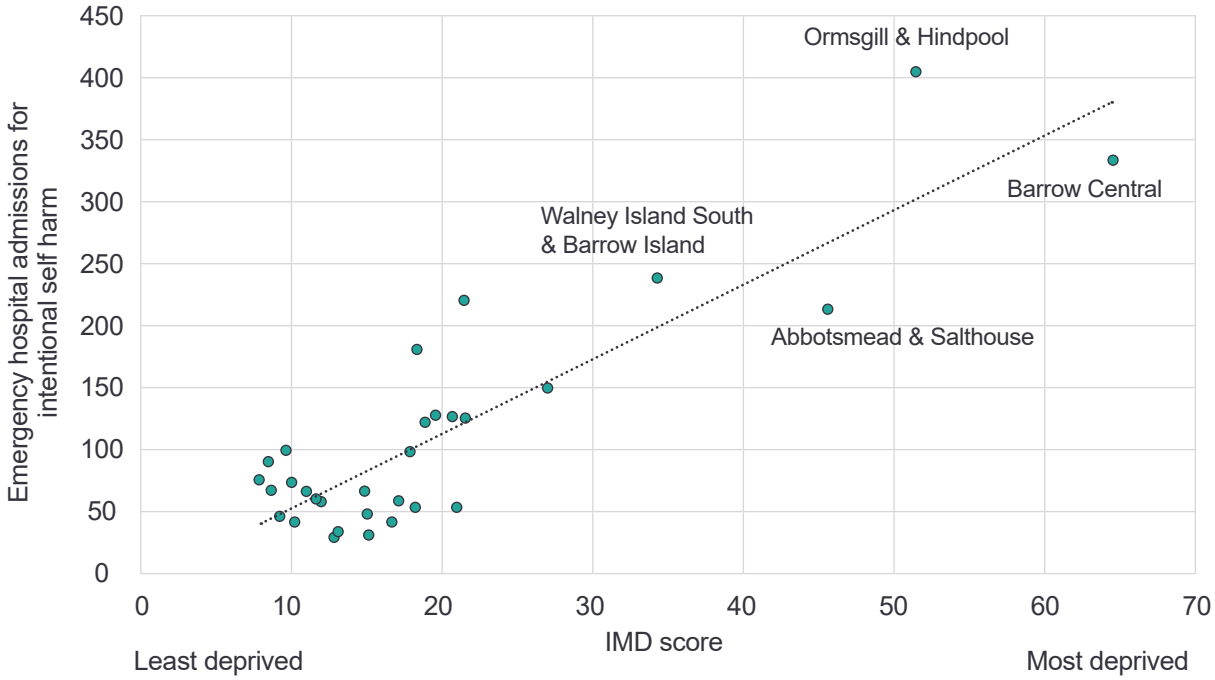
Table 7.10: Self-reported measures of life satisfaction, worthwhileness, happiness and anxiety in Furness, Eden and South Lakeland compared to England[1].

Indicator	England	Furness	Eden	South Lakeland
Overall, how satisfied are you with your life nowadays?	7.4	7.3	8.1	7.8
Overall, to what extent do you feel the things you do in your life are worthwhile?	7.7	7.6	8.2	8.0
Overall, how happy did you feel yesterday?	7.4	7.2	7.7	7.6
Overall, how anxious did you feel yesterday?	3.2	3.8	2.9	3.4

The rate of emergency admissions to hospital for intentional self-harm in Westmorland and Furness remains significantly higher than the national average but has reduced in recent years, following the regional North-West trend (Figure 7.12)[1]. At smaller area level (MSOA), there is an association between higher rates of admissions to hospital for intentional self-harm and our areas experiencing the highest levels of deprivation (Figure 7.13)[1].

Figure 7.12: Emergency hospital admissions for intentional self-harm in Westmorland and Furness, North-West and England, 2012/13 – 2022/23[1].

Figure 7.13: Emergency hospital admissions for intentional self-harm by MSOA in Westmorland and Furness, 2016-2020[1].

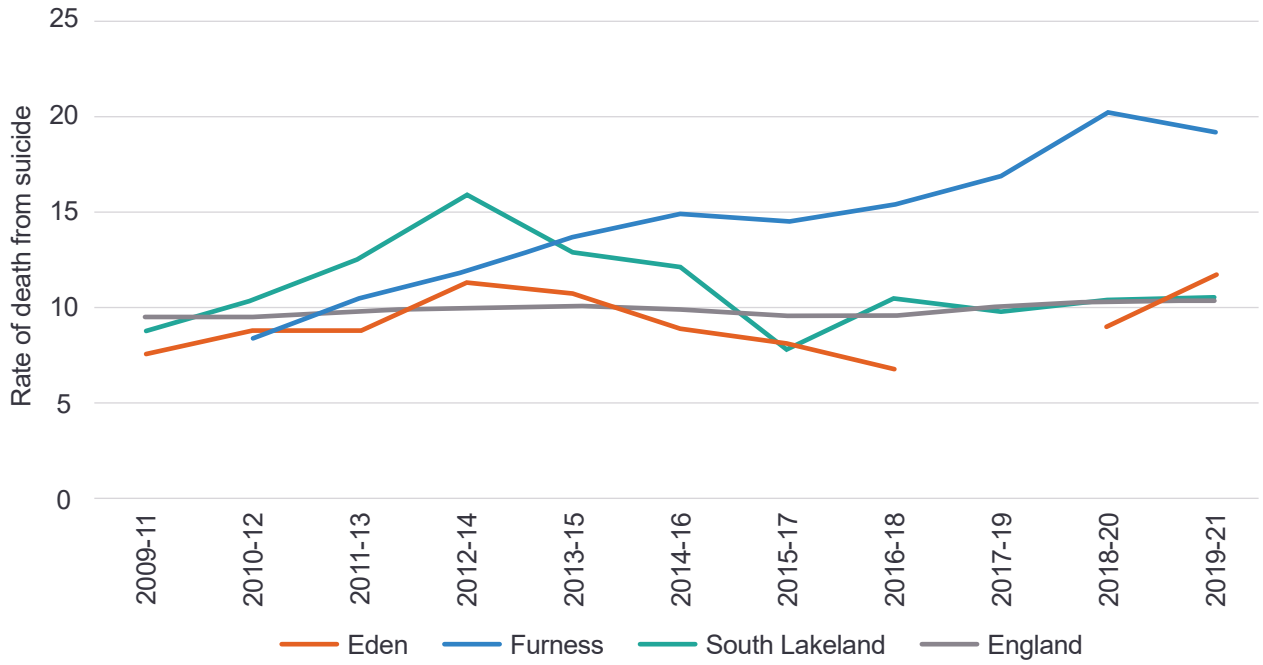


Sadly, the rate of death from suicide in Westmorland and Furness in both males and females is also significantly higher than the national rate, at 15.5 per 100,000 population overall compared to 10.7 per 100,000 population in England (1). Figure 7.14 shows the rate of death from suicide at locality level; Furness had the highest rate of death from suicide in 2019-2021[1].

Table 7.11: Rates of death from suicide in Westmorland and Furness, North-West and England, 2021-23[1]. *Red boxes indicate significantly higher SMRs than the national average, orange boxes indicate SMRs that are similar to the national average and green boxes indicate significantly lower SMRs than the national average.*

2021-2023	Westmorland and Furness	North West	England
Rate of death from suicide (persons, aged 10 years and over)	15.5	13.3	10.7
Rate of death from suicide (males, aged 10 years and over)	20.9	20.4	16.4
Rate of death from suicide (females, aged 10 years and over)	10.3	6.7	5.4

Figure 7.14: Rate of death from suicide in Furness, Eden, South Lakeland and England, 2009-2011 to 2019-2021. Missing data points from Eden are due to withheld data due to small numbers[1].



7.6 Summary

This chapter provides an overview of the leading causes of mortality for adults in Westmorland and Furness in order to identify shared preventable risk factors and highlight key areas for action. Compared to England, the standardised mortality ratio (SMR) for deaths from all causes in 2016-2020 was higher in Furness and lower in Eden and South Lakeland. Differences in mortality rates between populations sadly reflect health inequalities between different population groups, and this is further demonstrated by examining the SMRs for deaths from all causes at electoral ward level, which shows significantly higher SMRs in some of our areas experiencing the greatest levels of deprivation.

The leading causes of death in Cumbria are cardiovascular disease, cancer and chronic respiratory disease, which share a number of preventable risk factors, including smoking, living with overweight or obesity and alcohol use. In younger adults in Westmorland and Furness, substance misuse is the leading cause of death, with recent data showing significantly higher rates of death from drug misuse in Westmorland and Furness than are seen nationally. Significantly higher rates of admissions to hospital for intentional self-harm and deaths from suicide are also seen in Westmorland and Furness, with an association between higher rates of admissions to hospital for intentional self-harm and our areas experiencing the highest levels of deprivation.

7.7 Recommendation

Many of the diseases that cause ill health in Westmorland and Furness are associated with common risk factors and can be prevented.

Actions to prevent and delay disease, and reduce risk, need to be implemented at both a population and individual level. This means that opportunities to improve health and prevent disease for current and future generations need to be explicitly considered in all public sector decision making. In addition, throughout public services, and in particular in the health service, we need to ensure that greater focus is given to early identification and proactive management of the causes and risk factors for preventable disease and mortality.

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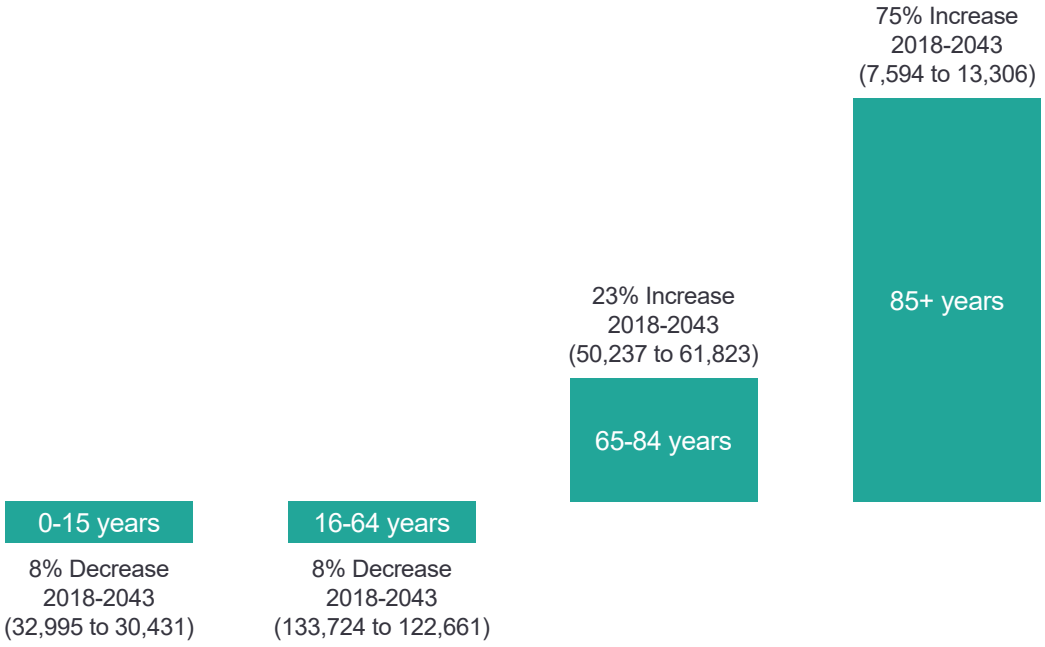
8. Ageing Well

Population projections indicate that the proportion of our population aged 65 and older, and particularly aged 85 and older, is set to increase significantly over the next twenty years in Westmorland and Furness[1]. This chapter examines the current and future needs of our older adults and the impact of multimorbidity and frailty.

8.1 Westmorland and Furness has an older population than the national average

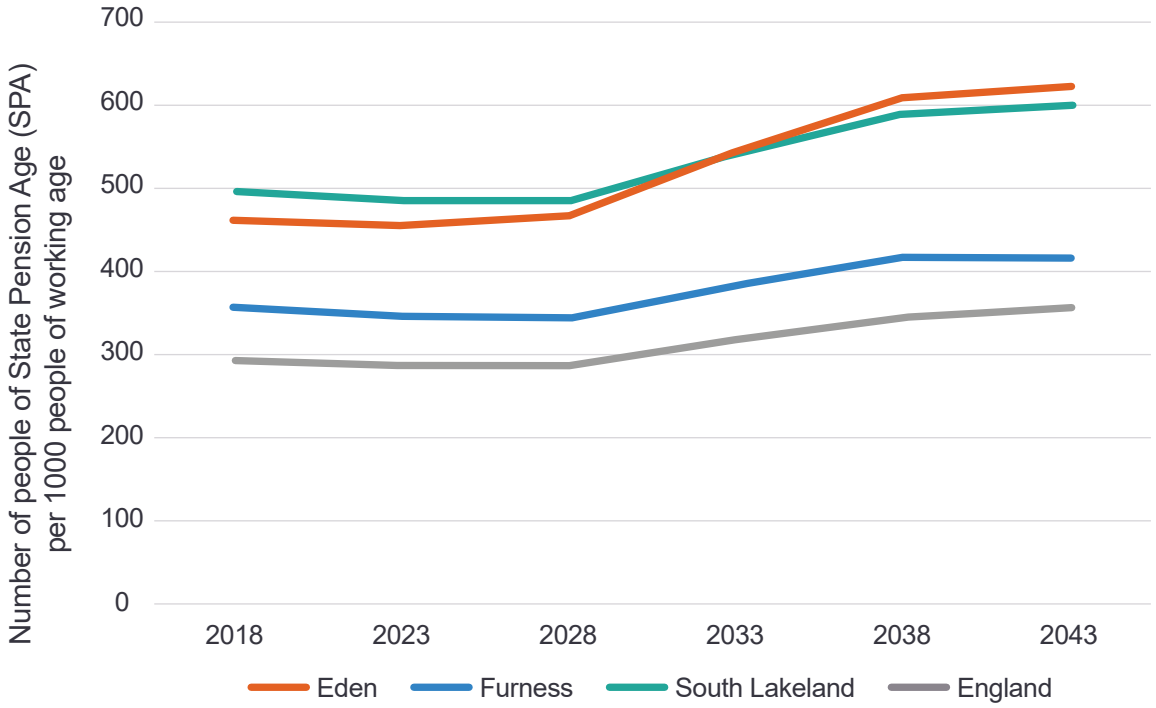
Rural and coastal areas in the UK are ageing at a much faster rate than urban areas[2]. This trend is evident in Westmorland and Furness, with population projections showing that the proportion of the population aged 65 and over is anticipated to increase by 30% between 2018 and 2043[1]. Over this period, the population aged 85 and over is expected to increase by 75%[1].

Figure 8.1: Westmorland and Furness population growth projections by age, 2018-2043[1].



This is forecast to be accompanied by a fall in our working age population, leading to an increase in the old age support ratio (or old age dependency ratio)[3]. This measures the number of people of State Pension Age per 1,000 people of working age and has been relatively static over the last 50 years. Whilst the old age support ratio is expected to rise nationally in the coming years, it is projected to rise more steeply in Eden and South Lakeland[3]. In 2043, it is projected that there will be 62 people of State Pension Age for every 100 people of working age in Eden[3]. For comparison, in 2043 in England, it is projected that there will be 36 people of State Pension Age for every 100 people of working age[3].

Figure 8.2: Historical and projected old age dependency ratios for Eden, Furness and South Lakeland compared to the England average, 2018 to 2043[3].

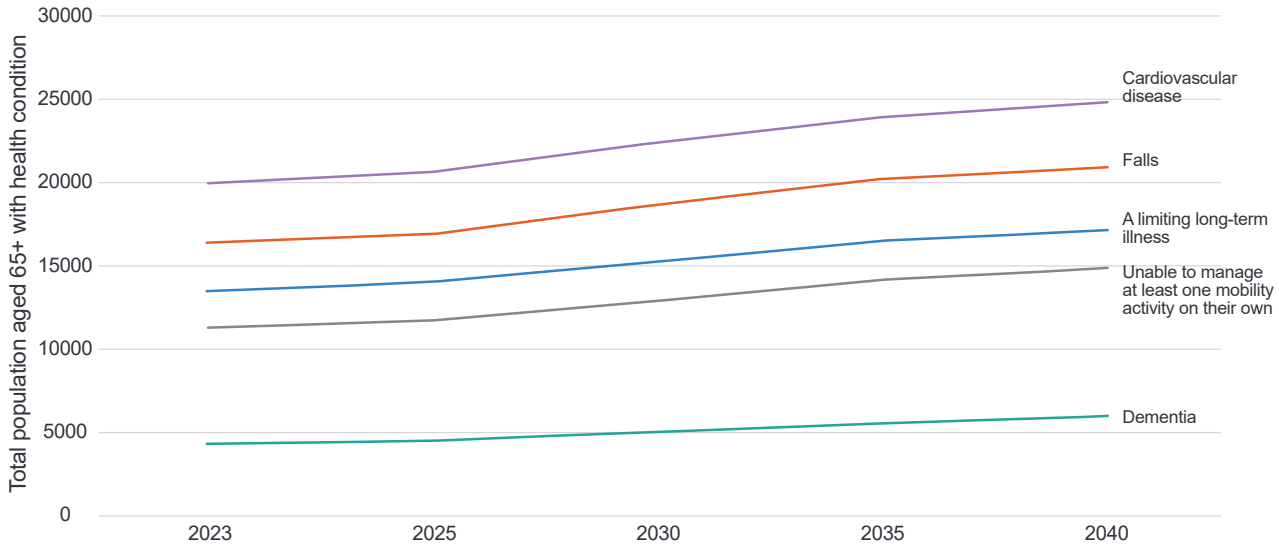


8.2 Ageing is not experienced universally by all

As we age, we are more likely to develop multiple long term health conditions, termed 'multimorbidity', and have increasingly diverse and more complex health and care needs. We also become at increased risk of developing frailty. Frailty is a long term condition and describes a health state in which individuals lose their inbuilt reserves, placing them at increased risk of sudden changes in their health from minor events, resulting in increased hospital admissions and social care needs[4]. Everyone is at risk of developing frailty, but this risk is compounded by the existing inequalities in health and outcomes experienced by different population groups and communities[4]. In particular, there is evidence that frailty occurs at higher prevalence and at younger ages in individuals and communities experiencing greater deprivation[4]. Frailty and multimorbidity do not always occur together; it is estimated that approximately 7 out of every 10 adults living with frailty also experience multimorbidity, but less than 2 out of every 10 adults experiencing multimorbidity will also live with frailty[4].

Nationally calculated figures indicate that, by 2040, the proportion of people aged 65 and over in Westmorland and Furness living with a limiting long term illness is forecast to rise by 27%; the proportion of people living with dementia is forecast to increase by 38%; the proportion of people living with diabetes is forecast to rise by 22%; and the proportion of people living with cardiovascular disease is forecast to rise by 24%[5] (Figure 8.3).

Figure 8.3: Population projections and forecasts for increases in long-term illnesses in Westmorland and Furness, 2023 to 2040[5].



Whilst the proportion of older adults living with multimorbidity is projected to increase more steeply in Eden and South Lakeland in the coming years, the proportion of adults living with frailty (who are at increased risk of worse outcomes and hospital admissions) is already estimated to be higher in Furness[6]. Recent research from 2020 estimates that 13.1% of males and 15.8% of females in Furness aged over 50 live with frailty, with a further 14.5% of males and 16.2% of females at increased risk of developing frailty[6]. This compares to 6.3% of males and 7.9% of females estimated to be living with frailty in Eden, and 4.4% of males and 5.4% of females estimated to be living with frailty in South Lakeland[6].

Table 8.1: Estimates of pre-frailty and frailty in the over 50 population of Furness, Eden and South Lakeland compared to England, 2020[6].

Estimate of pre-frailty and frailty in the over 50 population of each local authority, 2020	England	Furness	Eden	South Lakeland
Males, pre-frail	8.7%	14.5%	8.1%	7.8%
Females, pre-frail	11%	16.2%	9.7%	9.3%
Males, frail	6.8%	13.1%	6.3%	4.4%
Females, frail	9.1%	15.8%	7.9%	5.4%

These estimates and projections emphasize the need to have a greater focus on preventing ill health and disease in Westmorland and Furness. Secondary prevention is of increasing importance in an ageing population[7]. In the previous chapter, it was established that the leading cause of death in Cumbria is cardiovascular disease. An individual's chance of developing early pathological changes that increase the risk of cardiovascular disease, such as those associated with high blood pressure and high cholesterol, increase as we age[8]. By identifying and managing these early changes, the onset of ill health can be delayed, meaning that people live with better quality of life for longer, even irrespectively of any potential changes to overall life expectancy.

8.3 Preventing falls

Falls are a leading cause of emergency admissions to hospital in adults aged over 65[9]. Falls can occur as a result of multiple factors, including problems with balance, muscle weakness and atrophy, visual impairment, certain medications and combinations of medications (termed polypharmacy), medical conditions and hazards in the environment that can increase the risk of trips and falls[10]. Older adults are also at increased risk of osteoporosis, which places people at increased risk of developing a fracture following a fall[10].

In 2022/23, there were 1,115 emergency admissions to hospital as a result of falls in people aged 65 and over in Westmorland and Furness[9]. This is a similar rate to the national average[9] (Table 8.2). It is estimated that one in every twenty falls leads to a fracture and admission to hospital[11].

Table 8.2: Rates of emergency hospital admissions due to falls and mortality rates from accidental falls in Westmorland and Furness, North-West and England[9].

Red boxes indicate significantly higher outcomes than the national average, orange boxes indicate outcomes that are similar to the national average and green boxes indicate significantly lower outcomes than the national average.

Table 8.2: Rates of emergency hospital admissions due to falls and mortality rates from accidental falls in Westmorland and Furness, North-West and England[9]. *Red boxes indicate significantly higher outcomes than the national average, orange boxes indicate outcomes that are similar to the national average and green boxes indicate significantly lower outcomes than the national average.*

	Westmorland and Furness	North West	England
Emergency hospital admissions due to falls in people aged 65 and over, 2022/23	1850	2139	1933
Emergency hospital admissions due to falls in people aged 65 to 79, 2022/23	821	1055	928
Emergency hospital admissions due to falls in people aged 80 and over, 2022/23	4833	5283	4485
Mortality rate from accidental falls, all ages (persons), 2021-23	10.2	17.2	13.7
Mortality rate from accidental falls, all ages (males), 2021-23	11.5	21.1	17.1
Mortality rate from accidental falls, all ages (females), 2021-23	9.0	14.4	11.3

In 2022/23, 65.2% of males and 59.4% of females aged 65 and over in Westmorland and Furness were active for at least 150 minutes per week[9]. Activities to improve strength and balance are key in reducing the risk of falls and related injuries[11]. In 2023/24, 0.7% of adults aged 50 and older in Westmorland and Furness were diagnosed with osteoporosis, which is less than the national prevalence of 1.1%[9].

8.4 Dementia

Dementia is characterised by a decline in cognitive functions, including memory, language, executive functions and social recognition, leading to increasing impairments that impact on an individual's daily life. Increasing evidence suggests that, on average, dementia is diagnosed a number of years after the onset of symptoms, with one study researching the natural history of dementia reporting a decline in the instrumental activities of daily living 10 years before dementia was clinically diagnosed[12]. Timely diagnosis of dementia is important to allow people to access appropriate early care and support.

The estimated dementia diagnosis rate in adults aged 65 and older in Westmorland and Furness is significantly lower than the national figure[9]. However, the mortality rate from dementia and Alzheimer's disease in 2023 was similar to the national rate[9]. Further research is required to determine if these findings are due to a lower prevalence of dementia in Westmorland and Furness, or a lower diagnosis rate of dementia.

Table 8.3: Estimated dementia diagnosis rate and mortality rates from deaths due to and involving dementia and Alzheimer's disease in Westmorland and Furness, North-West and England[9]. *Red boxes indicate significantly worse outcomes than the national average, orange boxes indicate outcomes that are similar to the national average and green boxes indicate significantly lower outcomes than the national average.*

	Westmorland and Furness	North West	England
Estimated dementia diagnosis rate (aged 65 and older), 2024	59.3%	68.9%	64.8%
Mortality rate from dementia and Alzheimer's disease, all ages (persons, 1 year range), 2023	102.0	125.3	111.7
Mortality rate from deaths involving dementia and Alzheimer's disease, all ages (persons, 1 year range), 2023	141.6	170.8	158.8

Case study: Ageing Well in Eden - Dementia Friendly Communities Partnership

Eden has developed a new Dementia Friendly Communities Partnership, with a successful launch event in Penrith in 2023. The day consisted of information stalls from a wide range of organisations and inspirational talks from Councillor Patricia Bell, Public Health, Alzheimer's Society, Eden Primary Care Network, Carlisle and Eden Carers, and Active Cumbria. The launch also heard from people who shared their own very personal stories about how they have been affected by dementia.

A fully booked Dementia Friends information session gave people a deeper understanding about some of the small things we can all do to make a big difference to support people living with dementia. These sessions are now being made available to staff, elected members and wider communities and businesses.

The Eden Dementia Friendly Communities Partnership brings together local charities, community and faith groups, health and emergency services, local councils, businesses and people with lived experience. The Partnership's mission is to raise awareness of dementia risk factors, prevention strategies, and early signs of dementia, as well as providing information on local support, services and activities for individuals affected by this condition, and their families and carers.

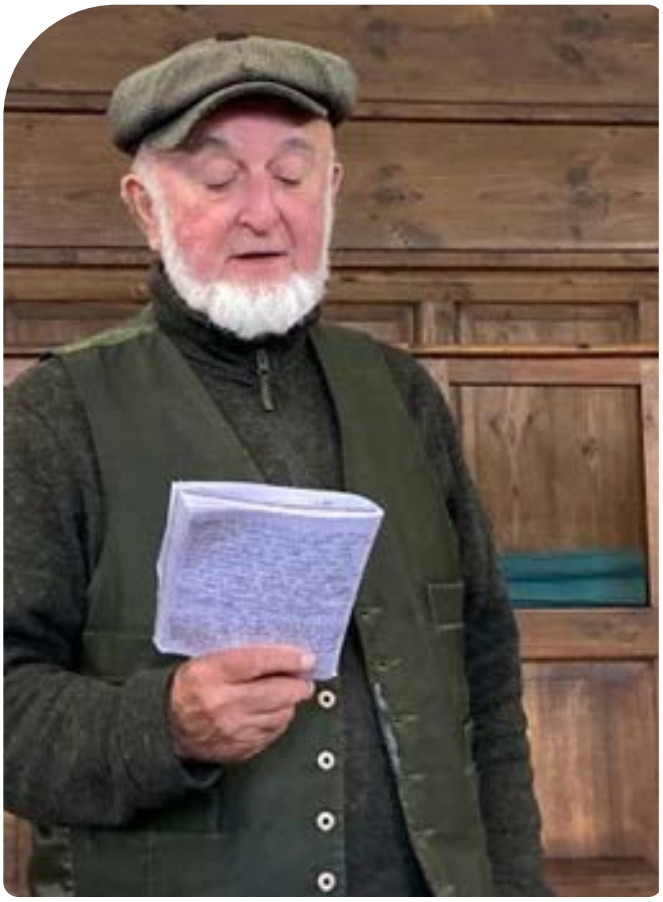
The Partnership now aims to investigate reasons for low rates of diagnosis locally, mobilise primary care, and undertake further community awareness raising. Gaps in provision of community support will also be explored.

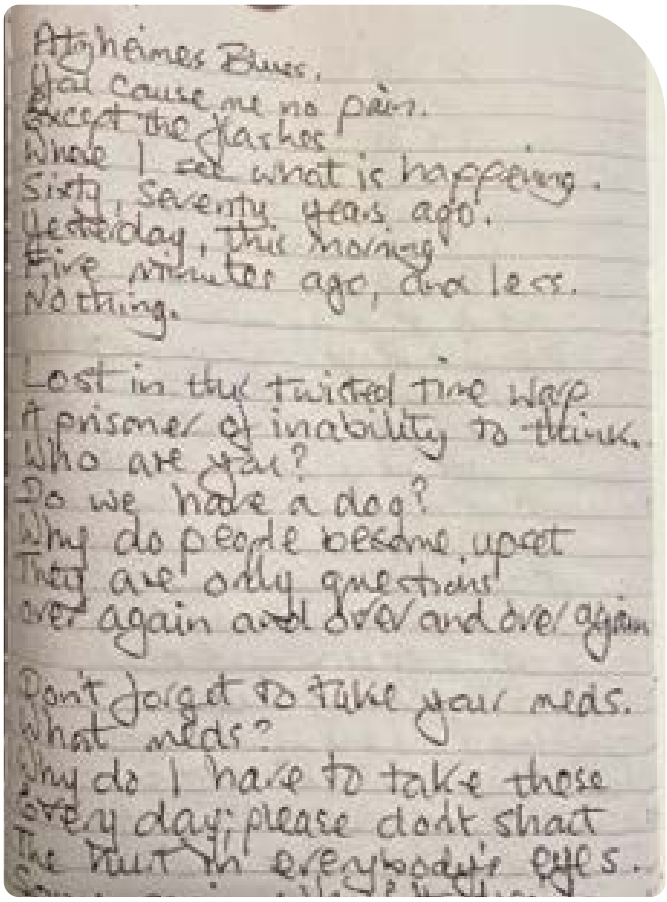
Whilst there is no cure for dementia, it doesn't mean that people can no longer socialise and be active within their community. We want people to feel confident that if they need help, others will have a better understanding of dementia and be able to support them. We want to encourage everyone to think more positively – some of the small changes we can make to our environment, and to our attitudes, can make a real difference to people who are living with dementia.

We also want to raise awareness that dementia is not an inevitable part of ageing, as many people think. There are steps everyone can take to reduce the risk, such as stopping smoking, being physically and socially active, eating healthily and drinking less alcohol.

8.5 Social isolation

Social connections are essential for our health and wellbeing, with loneliness increasing the likelihood of early mortality, as well as poor physical health and mental health[13]. Within Cumbria, just 35.7% of adult social care users over age 65 had as much social contact as they would like in 2021/22[9]. Recent community engagement conducted by the Public Health team on community health and wellbeing priorities has found that loneliness, social isolation and digital exclusion have worsened since the pandemic and that this is a key priority for local action[14].





8.6 Summary

This chapter provides an overview of the current and future health needs of older adults in Westmorland and Furness. Population projections indicate that the proportion of our population aged 65 and older, and particularly aged 85 and older, is set to increase significantly over the next two decades, accompanied by a fall in our working age population, particularly in Eden and South Lakeland. This is forecast to be accompanied by an increased number of adults living with long-term illnesses impacting on their daily lives, multi-morbidity and frailty. Older adults are at increased risk of falls and subsequent admissions to hospital, dementia and social isolation. Recent data shows that the estimated dementia diagnosis rate in adults aged 65 and older in Westmorland and Furness is significantly lower than the national average, with further research required to determine if this is due to a lower prevalence or a lower diagnosis rate. Support to reduce falls, maintain independence and prevent social isolation have been highlighted as key priorities for residents in recent community engagement.

8.7 Recommendation

Our population is ageing, and more people are living with multi-morbidity and frailty. This national trend is particularly pronounced in Westmorland and Furness, with the working age population reducing more quickly, and the population of over 65 year olds increasing more rapidly than the national average. It is therefore imperative that we take action to support our residents to live with independence, in better health for longer, and maximise the quality of life experienced by all.

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9. Recommendations

9.1. Considerations of health equity need to be at the forefront of decision making in all sectors, with policy, service design and investment decisions aligned to the actions recommended by the Health Equity Commission for Lancashire and Cumbria in the 2022 report.

9.2. Across Westmorland and Furness we need to take a 'Health In All Policies' approach, considering the opportunities to improve and protect health in all decision making on the building blocks of health, including (but not limited to) economic, housing and planning policy.

9.3. Given the significant impact of poverty on health and wellbeing, there needs to be concerted effort to prevent poverty and mitigate its impact, including 'poverty proofing' public services. Action to address poverty should be informed by, and co-produced with, people with lived experience of poverty.

9.4. The first 1001 days of life are a critical time for physical, cognitive, and emotional development and therefore need to be given the highest priority in any strategies and programmes aiming to improve outcomes, and in the allocation of resources. There are some stark inequalities in outcomes for children and young people, and support for children and families, from early years through to adulthood, needs to be scaled appropriately to need in order to reduce these inequalities and improve outcomes for all.

9.5. Investing in services and support for children and young people needs to be given greater priority if we are to improve health and wellbeing in later life. This includes ensuring children and young people, and families, have access to a wide range of activities which support resilience, health and wellbeing, and reflect the needs and aspirations of the children and young people of Westmorland and Furness.

9.6. Actions to prevent and delay disease, and reduce risk, need to be implemented at both a population and individual level. This means that opportunities to improve health and prevent disease for current and future generations need to be explicitly considered in all public sector decision making. In addition, throughout public services, and in particular in the health service, we need to ensure that greater focus is given to early identification and proactive management of the causes and risk factors for preventable disease and mortality.

9.7. Our population is ageing, and more people are living with multi-morbidity and frailty. This national trend is particularly pronounced in Westmorland and Furness, with the working age population reducing more quickly, and the population of over 65 year olds increasing more rapidly than the national average. It is therefore imperative that we take action to support our residents to live with independence, in better health for longer, and maximise the quality of life experienced by all.

Westmorland & Furness Council

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