

Bidmead, Elaine ORCID: <https://orcid.org/0000-0003-0166-4506> and Stuart, Kaz ORCID: <https://orcid.org/0000-0002-7952-5779> (2021) Health Inequalities in Cumbria - Initial analyses of Survey Responses. Centre for Research in Health and Society, Carlisle.

Downloaded from: <http://insight.cumbria.ac.uk/id/eprint/6308/>

Usage of any items from the University of Cumbria's institutional repository 'Insight' must conform to the following fair usage guidelines.

Any item and its associated metadata held in the University of Cumbria's institutional repository Insight (unless stated otherwise on the metadata record) may be copied, displayed or performed, and stored in line with the JISC fair dealing guidelines (available [here](#)) for educational and not-for-profit activities

provided that

- the authors, title and full bibliographic details of the item are cited clearly when any part of the work is referred to verbally or in the written form
 - a hyperlink/URL to the original Insight record of that item is included in any citations of the work
- the content is not changed in any way
- all files required for usage of the item are kept together with the main item file.

You may not

- sell any part of an item
- refer to any part of an item without citation
- amend any item or contextualise it in a way that will impugn the creator's reputation
- remove or alter the copyright statement on an item.

The full policy can be found [here](#).

Alternatively contact the University of Cumbria Repository Editor by emailing insight@cumbria.ac.uk.

Health Inequalities in Cumbria

Initial analyses of Survey Responses



**CENTRE FOR RESEARCH
IN HEALTH & SOCIETY**

November 2021

University of
Cumbria 

NIHR | Applied Research Collaboration
North East and North Cumbria

For further information on this report, please contact:

Dr Elaine Bidmead, NIHR NENC ARC Senior Research Fellow, Centre for Research in Health and Society, Institute of Health, University of Cumbria – email: Elaine.bidmead@cumbria.ac.uk

Table of Contents

1. Introduction	3
2. Findings	3
2.1 Mental Health Services:	3
2.2 General Access to Health Services	6
2.3 Inequalities due to wider determinants	8
2.4 Inconsistency in service delivery across Cumbria	10
2.5 Access to General Practitioners	12
2.6 Other inequalities	12
2.6.1 Access to ambulance and emergency services	12
2.6.2 Waiting times for referrals due to COVID-19	12
2.6.3 Care for Ageing residents	13
2.6.4 NHS Dentists	13
2.6.5 Healthcare workforce	13
2.6.6 Access to pharmacies	13
2.6.7 Violence against women and girls	14
2.6.8 Patient advocates	14
2.6.9 Recognition of the role of the VCFSE sector in tackling inequality in young people	14
3. Conclusion	15
3.1 Equity in Healthcare	15
3.2 Equity in Health	16
3.3 Recommendations	17
3.4 Moving forward	19
3.5 Lancashire and Cumbria Health Equity Commission (HEC)	20
3.6 Health Equity Research Group	20
References	21

1. Introduction

The Centre for Research in Health and Society at University of Cumbria were keen to understand the most pressing health inequalities in Cumbria and the factors driving them so that we can target our research agenda on these needs.

To this end we conducted a short consultation with a range of stakeholders in Cumbria including practitioners, managers, commissioners, representatives and researchers. Contributors responded to an online survey which was open from 16 September to 31 October 2021 and 49 responses were received.

Respondents were asked to identify the most significant health inequalities in Cumbria; the factors contributing to that inequality; what research would contribute to better understanding; and what practice or policy solutions they thought would solve the issues identified.

Here we present an initial analysis of the findings.

2. Findings

2.1 Mental Health Services:

The greatest proportion of respondents (n=15) highlighted access to mental health services as one of the most significant health inequalities in Cumbria, for example:

‘Prompt, quality and simple access to services for all health conditions but especially for mental health services which if not accessed, exacerbate health conditions’ (resp7)

‘Mental health - the services aren’t there’ (resp8)

‘Poor access to mental health services for adults, especially when there is comorbidity links to substance use’ (resp14).

This issue was also highlighted with regards to services for children and young people:

‘Poor access to mental health services for children’ (resp14)

‘Mood disorders, especially anxiety in teenagers’ (resp15)

‘Lack of mental health services particularly for teenagers’ (resp21)

‘CAMHS [Child and Adolescent Mental Health Service] services remain inadequate, with long waiting times still. None of this is acceptable, the children of our county are being let down with their emotional wellbeing and mental health needs compared to adults’ (resp40)

‘If you’re a young person trying to acquire mental health support (specifically tier 3 which is CAMHS) you are likely to be on a 12-month waiting list. People in need of mental health support are left until they are at crisis point until they are seen’ (resp8).

Resp9 commented that ‘*Long waiting lists for services such as CAMHS cannot be easily solved by turning to private health care when you do not have the funds*’. They also highlighted a lack of councillors in schools ‘*due to a lack of funding*’, they believed that:

‘School councillors can act as a first step to a student getting help with their mental health as it is someone who they trust and who they find approachable, it is also in a familiar area ... they may feel more comfortable in’.

Resp13 argued that young people had been '*most affected by the pandemic*' but that the issues '*are generally not picked up soon enough by statutory organisations and even when they become a crisis, there are still long waiting lists*'. They believed that '*Early intervention*' and '*Investment in The Third sector*' could help with '*the massive overdemand on statutory services*'.

Problems with access was perceived to create further problems

'Because mental health affects every aspect of a person's life, can lead to a breakdown and can severely affect their physical health. Relationships suffer, school/work suffers and there just isn't the support in place. Only 11 percent of the NHS budget is spent on mental health.' (resp8)

'I think that the most significant issue is that people don't access health support quick enough because there are too many barriers to asking for help. The challenge, however, is that if the majority of people who ARE asking for help can't get this help, there is limited point in encouraging people who need help but are reluctant to seek it, to reach out' (resp7)

'They are significant, as it can be the difference between getting treatment which will a) increase in self-neglect b) increase in preventable deaths c) increase in the quality of their life d) decrease in Mental Health - suicide - self-harm' (resp14).

Respondents indicated poor mental health was an issue across Cumbria; although one respondent stressed that the locality of the problem was immaterial to the person experiencing distress:

'I don't think it is fair to consider as area specific, it should be individual specific. For example, there may be more county lines issues in Barrow, but that doesn't mean where it is happening in Eden, that is not as significant for those young people' (resp13).

Others thought it more notable in areas of high deprivation; for example, resp7 asserted that:

'People in deprived areas are less likely to seek help, less likely to know where to turn for help, less likely to push for help and advocate for themselves when help is not forthcoming, less likely to look around for options or be able to access options due to lack of confidence/health awareness/transport/money and because they are likely to feel overwhelmed by their current situation' (resp7).

Consequently, five respondents perceived the causes of poor mental health to be socio-structural, for example:

'Generations of poverty leading to a culture whereby people don't perceive they have choices (and mostly have fewer choices). Any funding that is aimed at addressing this rarely empowers those who suffer the most from inequalities to devise workable solutions to these issues in their own community' (resp7)

'Low income, being able to afford a car, vast areas of farming land between villages and towns with poor transport routes. Costs of public transport' (resp14)

'Lack of funds, lack of staff, many people on benefits, poor job opportunity, lack of education' (resp38)

'Anxiety and lack of social skills, life skills, academic attainment leading to depression, addictions etc due to COVID' (resp13).

Two respondents indicated the types of research they would like to see specifically on mental health. Resp8 wanted *'Research to analyse which groups/areas are most affected'* but asserted that *'in terms of mental health, we already know how to solve the issue it's just a case of funding'*. Resp14 suggested research asking *'paediatric health service managers for evidence of the psychological support provided for children with physical health conditions compared to adults'*, and commented that *'The results would be shocking I'm sure'*.

In terms of practice or policy solutions, several respondents pointed to better funding (resp8; resp16; resp14). Resp14 wanted increased *'funding for Children's Services/Pathways'* as *'children leaving care need more therapy support and workers'*. Other respondents highlighted the need for increased collaborative working. Resp7 highlighted the need for *'Funding to support the growth of resident led cross sector working over many years'* (7). Resp13 pointed to a *'lack of funding, lack of statutory resources, lack of understanding in some instances,'* and lack of collaboration in supporting the third sector to make a difference in young people's lives:

True collaboration and partnership working, stop the survival mentality and work together to provide the very best service to the young person, by recognising that your organisation may not always be the best to deliver services, there may be another local organisation with the specialism who are better placed to deliver. But this links back to lack of sustainable funding for essential services' (resp13).

Resp8 wanted the *'CAMHS staffing issue'* resolved. Resp14 wanted *'more children centre support for families in managing their mental and physical health at early stages, instead of firefighting'* and the provision of *'grief & therapy services in the west'* of the county. Resp38 highlighted a need for an *'Increase in health visiting and school nursing services'* as well as *'Better education re cooking and health'*.

In addition to the above, problems with mental health support for specific health conditions and mental health disorders were also highlighted. Resp34 highlighted *'Inequality of access to psychological therapy for neurology patients in South Cumbria'*. Whilst resp40 indicated that *'Only children with diabetes, CF [Cystic Fibrosis?] or cardiac conditions can access psychological support at present which is not acceptable'*. Resp14, highlighted:

'Extremely poor access to health assessment/support for those on the Autistic spectrum, especially children going through school transition from primary to secondary and growth/hormonal changes ...

Poor standard of support for those with substance use, including therapy ...

Poor standard of support for those suffering grief/childhood trauma/sexual/physical abuse'.

Resp18 pointed to Emotionally Unstable Personality Disorder (EUPD) which they believed to be *'underfunded and over diagnosed'*. This respondent reported that *'around 70% of our caseload are those with EUPD'* and that *'EUPD behaviours tend to cause a lot of distress, clinical time and emergency service time. Personality traits tend to cause conflicts between teams and lead to repeat A&E admissions'*. EUPD was said to be caused by *'Poor relationships between families and poor emotional regulation skills- old fashioned ways of parenting and bullying that is inherit across Cumbria ... sexual abuse also appears to be a big factor'* (resp18). Resp18 highlighted the presence of *'strong opinions about those with EUPD held by services which can lead to less care and attention given'*. In terms of research Resp18 pointed to the need for:

‘Research around gentle parenting techniques and building emotional regulation would be helpful, alongside intensive DBT being offered which is fully advised in the research and evidence base for EUPD. We appear to be focussed on fixing families in early life yet the adults with EUPD seem to have been left behind- the personality disorder network may also help’

Policy and practice solutions included *‘joint working protocols around risk-pathways for EUPD that are evidence based and structured’* together with *‘ongoing family resilience and regulation’* (resp18)

2.2 General Access to Health Services

The second most frequently mentioned health inequality in Cumbria was access to health services generally (n=14). This was cited as a problem specifically for those living in rural areas, more deprived areas, and West Cumbria generally, for example:

‘Access to adequate high quality acute health care. Our county does not trust the CIC [Cumberland Infirmary Carlisle] and often states would prefer to travel out of county for better, safer care. My GP advised my mother that if she had the chance to go to Newcastle she must take it, and that was from a Cumbria GP!!!’ (resp39).

‘Emergency Acute Hospital care in the West of the County. The West of the County is reliant on Carlisle Hospital and the Newcastle Trust Hospitals to provide the majority of care. I live in a financially deprived area of Cumbria, travel expenses to Hospitals which are 40+ miles away and the financial pressure this places on patients is extremely worrying especially when ill’ (resp23).

Problems with access to services is exacerbated by transport poverty, mentioned by 12 respondents.

‘Access to services because of rurality, poor access to transport, lack of understanding/awareness’ (resp1)

‘People living in deprived areas do not have easy access to a lot of health services, they can’t afford expenses of vehicle that they would need to make appointments that are outside of their local area, the cost of a bus or a taxi may have been money a family needed for food’ (resp9)

‘The services aren’t there. In areas such as Ewanrigg, where 1 in 3 don’t have a car’ (8).

‘Eden is regularly seen as affluent and not in need but the rurality, significant transport issues and elderly isolated population are all significant factors that make delivering care more costly and complicated’ (resp30)

‘Difficult or no public transport links from several smaller communities to Carlisle. Travel issues will cause anyone working hourly, or is self-employed to lose at least a half day’s pay, which they cannot recover. This can apply to the patient or a relative or friend who provides the transport. If it is an 11 am appointment, then a whole day’s pay can be lost. This does not happen so often in more densely populated areas. Not talked about, because no-one wants to admit that there might be a financial penalty in helping a relative – spouse or parent, but it can become an important consideration where there is a long-term illness, like cancer’ (resp10).

'Patients need to attend regularly for wound ulcer dressing, this can have an effect on attendance due to cost. Some patients have to travel 40+ miles to attend a clinic. [Attendance is] Dependent on public transport; rural villages are often isolated' (resp22)

'Difficulties in travelling to clinics. Expectant mothers with diabetes having to travel to Carlisle from West Cumbria. Difficult or no public transport links from several smaller communities to Carlisle' (resp10)

'Specialist health appointments changed without consideration to the person being able to access transport to get there' (resp14).

Respondents also commented upon being required to travel out of the county to receive treatment:

'Having to travel huge distances to receive treatment [including being] asked to go to Morecambe to receive covid vaccination. Not everyone can travel as we also have poor transport infrastructures if you do not drive or have access to a car' (resp20)

'Travelling out of county to Liverpool and wigan, cost to environment and myself on low wages' (resp19)

'Distance to centres ... Distance from major cities ... Distance from specialist services ... Travelling down to Lancashire and across to the North East is time consuming and costly when needing surgery' (resp32)

In addition, five respondents cited inequalities in access to treatment for a range of specific conditions, including for cancer and urology, for example:

'Poor access to treatment and support for cancer patients ... I have first-hand conversations with people who have to travel vast distances to get cancer treatment. (To Preston and Manchester)' (resp14).

'Cancer treatment, serious lack of adequate treatment provision' (resp17)

'Nearest cancer centre for patients in Barrow is Preston – 68.4 miles away. Radiotherapy is not provided by local hospitals, only chemotherapy. Travel issues are significant as they are one of the main factors in patient's reported distress re their cancer treatment/journey. Also causes further fatigue and physical exhaustion having to travel so far for treatment' (resp34)

'Lack of 24 hour Urology cover at FGH [Furness General Hospital]. Loss of 24 hour urology cover endangers people's lives' (resp21)

'Not ... enough stroke input for younger people' (31).

Problems with access to health services was thought mainly to be caused by inadequate funding for a large, rural, sparsely populated county, but also by failing to learn from the past, poor governance, staffing issues, and people retiring to the county:

'Poor funding, the way funding is distributed by population numbers when we are a large county with relatively small population' resp39)

'Government funding for the area. As it is a demographically sparse area, there isn't a large collective "voice" for the people who live here. Residents' education and understanding limit the influence they have on health care changes' (resp23)

‘Cost of delivering the services to a sparse, rural community in an area with poor public transport connections and large distances, both in time and distance between settlements and larger centres of population. Not talking and listening to patients and front line staff enough. Not looking back at ideas that have failed to work out why they failed. Sometimes approaching a problem from a different angle can alter the outcome’ (resp10).

‘Poor governance of the hospital trust [UHMB NHS FT]. Poor governance of the trust is a recurring theme and mentioned in the QCC investigations amongst others ... The trust model is not fit for purpose it seems to reward poor performance by senior administrators by allowing them to leave a scene of devastation as they waltz into another overpaid job. The same swine in the troughs’ (resp21)

‘Lack of transport, retiring to the countryside without thought for the consequences when you are no longer able to drive. Lack of social carers, reduction in health care staff’ (resp30).

Respondents wanted to see research undertaken to understand the travel distances to access treatments with reference to people’s financial ability to pay (Resp17, resp22, resp23). Resp39 wanted research to make explicit the amount of money *‘our health economy receives compared to other areas of a similar geographical (not population) size’*. Resp21 wanted research that would facilitate *‘A better model for health trusts’*.

Recognising that problems with access to health services is interconnected with problems of access more generally, respondents wanted to see better provision of health services locally (resp9; resp14; resp19, resp32) and improvements to public transport (resp10; resp14; resp30), for example:

‘Transport/location of clinics - make sure that they accessible by bus/train’ (resp10)

‘Subsidise the public transport and improve the service ... Return Health services to the West Hospital rather than expect people to travel to the city of Carlisle, or Newcastle. in some cases, travelling for more than an hour to hour and a half, on single lane road just to Carlisle’ (resp14).

‘Using local hospitals instead of big hubs’ (resp19)

‘Build a fit for purpose hospital especially as we are now going to be a unitary authority’ (resp20)

‘Better public transport. Better social care’ (resp30).

Resp39 advocated for local trusts to get *‘more support from Trusts that are performing better to help us to properly improve’*; they also wanted the way funding is decided to be examined and to *‘acknowledge we need more funding not just per head of population’*.

2.3 Inequalities due to wider determinants

Ten respondents mentioned inequalities in health due to deprivation and lifestyle factors, which can be conceptualised as the wider determinants of health, for example:

‘Lifestyle related illness in most deprived areas [caused by] Poverty, education, low levels of aspiration’ (resp2)

‘Access to services because of rurality, poor access to transport, lack of understanding/awareness [which is] absolutely concentrated in areas of poorer housing, joblessness [caused by] deprivation, insecure employment, poor transport, poor health’ (resp3)

‘People who are socially isolated that have pre-existing health conditions that have worsened during COVID, especially those who are struggling financially [...] can be seen across Cumbria, for example in deprived communities and in rural communities’ (resp5)

‘Anxiety and lack of social skills, life skills, academic attainment leading to depression, addictions etc due to COVID’ (resp13).

Several respondents commented upon poor diet and/or obesity (malnutrition) which they believed due to the poor availability of nutritious foods and knowledge of how to cook ‘*from scratch*’:

‘In areas such as Ewanrigg, Maryport, where 1 in 3 don’t have a car and the nearest shops don’t stock fruit or veg, I would say that physical health is a huge concern ... I would say that the issue surrounding shops only stocking unhealthy food is mainly prevalent in more impoverished coastal areas such as Ewanrigg’ (resp8).

‘Healthy nutritious fresh food is much more expensive than high carb/fat/sugar unhealthy food. Lots of people don’t have the skills, confidence, resources to know what to do and how to do it [due to] Financial [situation], knowledge, skills, motivation to change, fear, lack of confidence’ (resp5).

‘Poor diet high in processed foods, obesity and inactivity especially in low-income households’ (resp15).

‘Deprivation; lack of aspiration from young people; food insecurity; overweight; obesity in children and young people, [these] have the most long-lasting affect on people's health and wellbeing [and] occur mostly in our deprived wards and particularly west coast’ (resp12)

‘Obesity, diabetes [caused by] Poor diet choices. Lack of physical exercise, poor motivation to change diet and exercise regimes’ (resp24)

Resp15 argued that ‘*Obesity and inactivity are complex and multi factorial issues related in part to upbringing, educational attainment and access to raw ingredients/knowledge of from scratch cooking*’. They asserted that people in low-income households have:

‘Low expectations of life chances. Children of poorer families do not realise their potential at school. They give up sooner. Parents are unwilling or unable to support their children in later years of secondary education and especially 16-18years, where travelling to school or college is ridiculously expensive. Apprenticeships are poorly paid and low earning parents can’t support them through this learning. All this perpetuates low social status and inability to change’

Others pointed to behaviours like smoking, alcohol and drugs. Resp9 argued that

‘In areas of poverty people are not given the information or funding to promote and prevent the risks associated with the use of smoking, drinking, drugs or even pregnancy. They are also exposed to overall poorer living conditions ... It should be mandatory to teach children healthy ways of living and promote them’ (9)

Resp12 believed the causes to be:

'lack of opportunities for young people; lack of education around healthy eating and cost of food, lots of people don't know how to cook so just buy takeaways; planning depts not linking in with health outcomes; lack of jobs or the majority that are available particularly in the west - young people have to have min C grades in their GCSEs and the GCSEs attainment levels are not good so the young people are disadvantaged and end up in low paid roles with no future' (resp12)

Resp12 asked for '*research around young people's aspirations and why they think it's ok to not strive for more*'; resp15 said to '*Ask the educators what holds children back from achieving their potential*'. Resp24 wanted to know '*What effect, if any does prescription of exercise or weight loss programmes have on this problem. Is it just short-term effect or longer adjustment of behaviour?*' Resp7 wanted to see more qualitative research undertaken with '*a cross section of our more deprived communities*'. Similarly, resp14 recommended research to '*speak to the people directly; [to] capture their voice*' be undertaken in each town, to include conversations with GPs and their patients; third sector organisations including children's centres, community centres, voluntary centres, Libraries, A&E, addiction Services, Probation Services, and Children's Services; they highlighted how data analysis obscures the extremes in income in the county. Resp9 wanted to see research that will expose '*people in power to the difficulties that people in low-income areas face when it comes to health care*'.

Resp3 believed tackling these wider determinants required '*Looking at a longer-term strategy rather than short term approaches*'; resp12 believed the situation would be helped by '*more joined up and collaborative partnership working*'; Resp5 pointed to the need to work '*alongside communities and give them the choices that they want and need and support them to do so*'; and resp15 argued for '*Free transport to 16+ education, better financial support for apprentices, widespread access to sporting facilities for families*'. Resp24 wanted to see:

'More firm advice to clients about their weight gain and consequences to their health, simplified use of scale, something like the Japan model of girth which is easy to record [...] Health professionals need to wake up to the obesity problem within their own profession- too many staff now obese themselves and this cannot send the right message to clients when we are advising them to lose weight and lead a healthy life'

2.4 Inconsistency in service delivery across Cumbria

Six respondents highlighted inconsistencies in the availability of services and treatments across the county. Some asserted that services are better in the North of the county, others asserted they were better in the South, and West Cumbria was underserved in comparison to Carlisle. This perhaps reflects the competition for scarce resources in Cumbria.

Moreover, Resp34 referred to a '*North/South divide in Cumbria*' due to differing commissioning decisions. Resp34 was focussing on the provision of the Persistent Physical Symptoms Service and other support services which are only delivered in North Cumbria, this leads to inequality in access for patients in the South. They argued:

'Commissioners in South Cumbria not willing to commission PPSS service in South despite evidence it is the best service model for pain management and long terms conditions and is commissioned in North Cumbria successfully and is saving NHS money in long term. Inequality of access to psychological therapy for neurology patients in South Cumbria too – same reasons – commissioners unwilling to commission, but service in North Cumbria is very successful [...] NCIC trust is commissioned to provide PPSS, Familiar Faces, Neuropsychology services but only in North Cumbria. The same services could be available in South Cumbria but commissioners in South will not buy into this despite years of negotiation so currently there is a known gap in services [...] Patients are going without a service that they desperately need and that could be available if they were commissioned'.

Resp6 focussed on continuing healthcare decisions; they asserted that there are *'Differences in NHS Continuing Healthcare decisions in the North and South of the county'* which leads to variance in the support available to patients based upon where they live. They believed people are *'more likely to be awarded this funding in the south of Cumbria rather than the north'*.

Resp10 referred to *'Inconsistent care for long term conditions, e.g., diabetes, COPD'*. Resp37 highlighted *'Different ICC Hubs developing diverse services'* which resulted in fragmented provision and *'No equity for patients'*. Resp28 argued that *'West Cumbria is an area of deprivation, so health outcomes are poorer'*, but highlighted *'West Cumbria does not have the same provision as Carlisle'*; they believed *'Difficulty recruiting qualified staff to West Cumbria'* contributed to this inequality.

Finally, resp41 referred to *'the variance in service and care from GP practices'* due to some practices experiencing staffing instability; they believed this was caused by *'GP fundholding and practices being run like a business rather than governed by the NHS directly'*.

With regards research, resp6 argued for the *'Collation of numbers of cases taken to the panels and their outcomes to identify on what reasons and why there are differences in outcomes for different areas of Cumbria'*. Resp10 wanted a focus on long-term care:

'A paper audit of the provision of long-term condition care, interviews with patients with long term conditions. This could be done with group discussions. Review of what was planned in the past, was it delivered, did to work, if not - why did it not work'

Resp37 called for an *'overall look at ICC Hubs and what each one offers'*; whilst resp34 called for:

'Cost-benefit analyses of providing centres closer to home maybe? Research into how NHS services are commissioned across the country - how much is subjective vs standardised procedures for deciding which services to invest in?'

Lastly, resp41 suggested an *'audit [of] GP activity of a stable practice compared to those that are known instable'* and that any research should *'ask the patients'*.

Two respondents recommended attention be paid to commissioning of services, resp34 argued for *'Clearer policies re commissioning of NHS services'*; they believed the *'Problems are at the commissioning level not on the ground'*. Resp6 pointed to the *'Variance of those who sit on the panels'* and recommended that commissioners *'attend other panels to understand where differences are arising'*. Resp6 also asked that *'Recommendations and rationales from those submitting positive Decision Support Tools are treated with professional respect rather than being consistently challenged as inadequate'*. With regards GP services, resp41 recommended that *'when a GP practice gets into difficulty the NHS should take over not another private company'*.

2.5 Access to General Practitioners.

Six people highlighted inequalities in accessing GPs; four of whom argued against online consultations and a return to face-to-face appointments, for example:

‘Local GP practices patient consultations online, only due partially to covid but prevalent before the pandemic. [These] Can miss initial signs of serious disease or complications – or wrong diagnosis’ (resp4).

‘Access to a GP face to face ... when speaking to patients in my clinics, complaints about not getting in to see a GP; reports from patients can't get help they need [...] GP, still living under covid umbrella when all other services have resumed regular face to face’ (resp26).

Resp4 believed this situation was caused by a ‘*lack of government guidance to local authorities*’, which needs to be better and stronger.

Resp14 highlighted ‘*extremely poor access to health services via local GPs*’. They argued that ‘Vulnerable people ... are kept on hold on average [for] an hour to speak/make an appointment with the GP’.

Resp10 highlighted the lack of a ‘*specific doctor in a practice specialising in a long-term condition[s]*’ at their GP practise; they believed some other practices to have these. They recommended that GP practices ‘*learn and put in place systems which have worked in the past*’ and:

‘Make practices devise a system where there is some continuity for the patient by a Doctor. At the moment, it is possible for none of the Doctors to know the full picture of a patient with a long-term condition, so if there is a crisis, the patient has no-one who they know or trust to turn to.’ (resp10).

2.6 Other inequalities

2.6.1 Access to ambulance and emergency services

This issue was mentioned by three respondents. They stressed the lack of services to ‘*isolated communities*’ (resp11), resp38 reported ‘*Poor emergency cover, little ambulance cover in Millom*’, and resp17 reported having waited ‘*over half an hour for an ambulance for my 6 yr old daughter who was having a fit, this is unacceptable esp[ecially] when they said they had to go from Barrow to Lancaster then back to Kendal*’.

The need for ‘*more ambulances in all areas*’ was stressed by resp17. Resp11 called for ‘*improved fund[ing] and organisation*’ noting that ‘*Because this only affects a relatively small number of people, it gets ignored by the NHS and politicians*’.

2.6.2 Waiting times for referrals due to COVID-19

Three respondents commented on ‘*Waiting lists from Covid*’. Resp7 commented that ‘*Referrals to services have always been slow but are now even slower during Covid*’. Resp32 argued that ‘*Delays in treatment and availability of specialist services can have serious consequences*’. And this was illustrated by resp19:

‘It has taken me six months to be seen, maybe due to covid. By the time I was seen my tendons had gone back so far that my shoulder is unsuitable for the operation, and I have been left with 40% use’.

2.6.3 Care for Ageing residents

Three respondents commented on this factor. Resp14 highlighted *'Very poor access to health services for the elderly'*. Resp31 pointed to an *'increasing ageing population'* and *'more people with dementia'*; they believed *'dementia most difficult to solve due to lack of care home provision'*, although they thought support was variable across the county. They believed the problem to be caused by a *'lack of funding, location, recruitment and training'* and therefore what was needed was *'more funding and training'*.

Resp25 also highlighted an ageing population in Cumbria together with a *'lack of carer services to support people needing care living at home'*. They argued that the problem *'Varies by district due to demographic differences. It appears more deprived areas get more support and services however affluent areas struggle to get the adequate funding or support.'* Therefore, they wanted to see attention given to areas with higher ageing populations. Resp25 recommended that:

'We need to be planning ahead. Over the next 15 years the ageing population will rise by a minimum of 11% in Eden. We are already struggling with care closer to home and as GP practices we are very concerned about the sustainability of health services in a geographically challenged area.'

2.6.4 NHS Dentists

Two respondents highlighted issues with dentists. Resp1 believed access to NHS dentists was *'an issue across Cumbria'* and believed the causes to be *'socio-economic; dentist satisfaction (not satisfied or happy working with the NHS)'*. They called for research to include a *'Socio-economic angle to the project - finding out if these factors affect the likelihood of getting a NHS dentist or a dentist'*. Resp1 argued that *'there has to be a specific number of NHS dentist places within an area - all children should have access to an NHS dentist, must be able to be seen within a specified time limit?'* Resp17 also highlighted dental care and reported they *'travel to Lancashire to an NHS dentist as I cannot get in one'* in Cumbria.

2.6.5 Healthcare workforce

Two respondents commented saying this is an issue in Cumbria due to staff retiring and struggles with recruitment to replace them (resp32). Resp40 highlighted that *'In my area: physical health psychology services are only 1% staffed compared to adult health psychology services despite our ongoing work to improve this'*

2.6.6 Access to pharmacies

Two respondents commented on this need. Resp38 highlighted *'No chemist in Millom after lunch on Saturday until Monday am'*; resp10 highlighted *'Not being able to buy over the counter medication from dispensing GPs'* they explained that:

'Bootle in West Cumbria is 5 miles from a pharmacy. Local shop stocks some over the counter medication, e.g., Gaviscon, Paracetamol. Prescription medication can be collected from the branch surgery between 9am and 12.30pm, four days a week - unlike the 24 hour access in many large towns. Afternoon access would be good'

Resp10 argued that *'The legislation needs to be changed to allow dispensing doctors to sell over the counter medication or make them work with a pharmacist to do it'*.

2.6.7 Violence against women and girls

One respondent. Resp36 argued that *'Violence against women and girls'* was an issue across the county where *'all services have waiting lists'*. They perceived a *'lack of strategy coordination and commissioning across the county leading to piecemeal provision and funding of non-specialist services'*. The causes of violence against women and girls included *'Lack of preventative and community based action, communication and education in schools, lack of long term funding for specialist providers. Lack of specialist support for CYP'*. Resp36 highlighted that *'There are currently 3 research projects being undertaken in Cumbria around this issue - with no coordination / link up'*. The problem could be addressed through *'Sustainable funding and commissioning; Specialist providers / not generic; Government and local awareness campaigns; Health buy in and recognition of this issues as a health issue'*.

2.6.8 Patient advocates

One respondent. Resp29 argued that:

'Patients who do not have advocates often struggle to be heard and do not always receive treatment and services which they are entitled to. I recently had to fight for services for a patient who was unable to speak any English. Everyone else had the attitude that this was not their role. It was not mine either, but had I not helped this patient would still be waiting for treatment.'

They believed that *'NHS systems don't talk to one another let alone ASC and NHS. Communication can be a barrier with service users often being passed around as it is not seen as their job to intervene'*. But *'people who are poor are often less educated so aren't aware of services available, aren't aware of what they are entitled to and are not able to be listened to in the same way as someone who is articulate'*. Therefore, there was a need for:

'More advocates for patients and for staff to not have the attitude of something not being their responsibility. Also, for a policy around not passing enquiries from one person to another because when I speak to people who have tried to access services this is what many have experienced, and it can be very frustrating'

2.6.9 Recognition of the role of the VCFSE sector in tackling inequality in young people

One respondent. Resp13 perceived a *'Lack of recognition that the third sector can play a big part in supporting young people with the right joined up approach and longer-term funding'* (13). Resp13 recommended research into how the third sector will fit with the Local Government re-organisation; they also wanted to see:

'Case studies to prove partnership programmes delivered by a number of local organisations all working together and not in conflict or duplicating services has much better outcomes for young people. Proof that intervention, support, delivery programmes by third sector organisations saves money and resources in the long term and has a much-improved outcome for the young people. Links to economy, so if a YP feels better, is more confident, gains social skills, they are in a much better place to secure local employment'. (Resp13)

3. Conclusion

3.1 Equity in Healthcare

Equity in healthcare refers to the arrangements that facilitate 'equal geographic, economic and cultural access to available services for all in equal need of care' (Dahlgren and Whitehead, 2006:7¹). The above findings suggest equity in healthcare is challenging in Cumbria; responses gave the impression of poorly joined up, fragmented provision and of a North, South, West divide.

Respondents reported uneven access to a range of services within Cumbria. Access to secondary care was highlighted; respondents reported patients having to travel extended distances to access services. A lack of services for specific conditions was emphasised, including treatment for cancer for which it was reported that patients must regularly travel huge distances, an example given was residents of Barrow travelling to Preston for Radiotherapy. Accident and emergency and ambulance services were also highlighted as problematic, especially for people residing in remote communities, such as Millom and Alston. Furthermore, issues of differential access were raised with regards to GP practices, NHS dentists, elderly and social care, pharmacies and over the counter medicines. Differences in commissioning were also reported between Morecambe Bay and North Cumbria Clinical Commissioning groups (CCGs).

Poor mental health and poor access to support for mental health was reported to be a problem across Cumbria for people of all ages, but particularly for those residing in deprived neighbourhoods and isolated rural areas. The lack of mental health services, and the long waiting times to access those available, was perceived to worsen mental health conditions; respondents highlighted the value of early intervention. In addition, access to a range of other supportive therapies was highlighted as problematic and variable across geographical areas, for example, therapies for people with long term conditions, pain management and psychological trauma.

Moreover, people living in Cumbria will experience different degrees of healthcare inequity depending upon where they live within the county; some will be required to travel significantly further to access care. For residents of South Cumbria within the Morecambe Bay footprint, some secondary care services are available at Furness General Hospital (which also offers accident and emergency services) and Westmorland General Hospital, if the service required is not available then it is Royal Lancaster Infirmary, Royal Preston Hospital or further still, possibly Manchester or Liverpool. For West Cumbrian residents within the North Cumbria footprint there are some services at West Cumberland Hospital, but after that it is the Cumberland Infirmary in Carlisle, Newcastle upon Tyne and other hospitals in the North East; similarly for residents of Eden district. Carlisle residents have relatively easy access to Cumberland Infirmary, but they may be required to travel to West Cumbria for some services/procedures, and further afield for specialist care. This situation is exacerbated by poor road and public transport connectivity. So, whilst NHS services may be 'free at the point of delivery,' when the point of delivery is many miles away there are significant issues in terms of cost and travel time. As such, distance to services creates significant barriers for people, especially those on low incomes, those with poor health, those with physical/mental disabilities, and those who do not have access to a car; people who are often the least able to pay.

Notwithstanding, funding was the most frequently cited cause of the problems with access to healthcare; respondents generally considered health services in Cumbria to be greatly underfunded for such a large, rural, sparsely populated county. Poor transport infrastructure was also cited as a causal factor. As such, better funding, better transport infrastructure and better located clinics were forwarded as solutions.

The delivery of health care in Cumbria is complex due to both the geography and the way that health is administrated; it is difficult to conceptualise it as a single health system. For example, there are two CCGs; two secondary care NHS foundation trusts; two mental health NHS foundation trusts; one upper tier local authority; six district councils; and one ambulance service, all of which are supported by a range of providers from the VCFSE sector - the Local Government reorganisation may lessen these complexities but will not remove them entirely. In addition, there are a variety of Integrated Health Communities (ICCs), two Integrated health Partnerships (ICPs) and two Integrated health Systems (ICSs); these aim to facilitate joined-up care (see table 1).

Table 1. Integrated Health

Integrated Care Communities	<p>Work together to improve the overall health and wellbeing of the community. The aim is to do this by:</p> <ol style="list-style-type: none"> 1. Joining up health and care services to work better together 2. Providing more care out of hospital where possible 3. Supporting people to have information about their health conditionsⁱⁱ. <p>There are 8 ICCs in North Cumbria and 8 in Morecambe Bay, 5 of which include areas in Cumbria.</p>
Integrated Care Partnerships	<p>Aim to improve how local services are designed and co-ordinated for the benefit of patients and service users in local communities. They are charged with</p> <ol style="list-style-type: none"> 1. delivering more integrated care for frail older people and those with specific long-term conditions, 2. preventing hospital admission by identifying patients most at risk and proactively working across health and social care to develop strategies to manage their health and social care needsⁱⁱⁱ
Integrated Care Systems	<p>Are partnerships between the organisations that meet health and care needs across an area, to</p> <ol style="list-style-type: none"> 1. coordinate services 2. plan in a way that improves population health and reduces inequalities between different groups^v

3.2 Equity in Health

Equity in health has been defined as:

‘The absence of disparities in health (and in its key social determinants) that are systematically associated with social advantage/disadvantage. Health inequities systematically put populations who are already socially disadvantaged (for example, by virtue of being poor, female, or members of a disenfranchised racial, ethnic, or religious group) at further disadvantage with respect to their health’

(Braveman and Gruskin, 2003:256^v).

Respondents to this consultation recognised health inequity to be caused by the synergetic effects of multiple factors upon individuals. They highlighted the presence of upstream factors such as weak labour markets (low skill, low paid, insecure jobs) and unemployment, poverty, poor connectivity/access to services, and obesogenic environments. Such factors combine to influence downstream, lifestyle factors such as diet, alcohol consumption, smoking, drug taking, low physical activity, low educational aspiration and attainment, and violence against women and girls.

Respondents identified upstream and downstream responses to tackle these wider determinants. Upstream responses included free transport, increasing sporting facilities, teaching healthy lifestyle skills in schools, patient advocates, and applying a health in all policies approach to planning. Downstream responses involved preventative, community-based action and education, and working alongside communities to understand their needs and supporting them in the achievement of these. Respondents highlighted the need for a long-term, joined-up strategy to tackle inequities in health to include collaborative, partnership working across all sectors.

Moreover, there are disparities in levels of advantage and disadvantage across the county. Economic deprivation can often be missed in higher level statistical analysis – due to data in larger, polarised wards being averaged out. Whilst there are known concentrations of disadvantage in some of Cumbria’s towns (most notably on the west coast), Cumbria also has many geographically marginalised communities where, even in the most idyllic locations, pockets of severe deprivation exist, much employment is low paid and insecure, and costs of housing and daily living are high. Cumbria also has a growing proportion of older people.

3.3 Recommendations

The situation with regards to equity in health and healthcare is challenging and given the current climate, cannot be fixed by NHS services alone – a situation recognised by several respondents who called for greater collaboration with the VCFSE sector. Therefore, there is a need for health and wellbeing eco-systems in Cumbria such as that illustrated in Figure 1. Health and wellbeing eco-systems aim to combine actions at all levels and across sectors, for example, health services (front line, managerial, commissioning), local authorities, local business and VCFSE, together with the development of participation structures for community engagement.

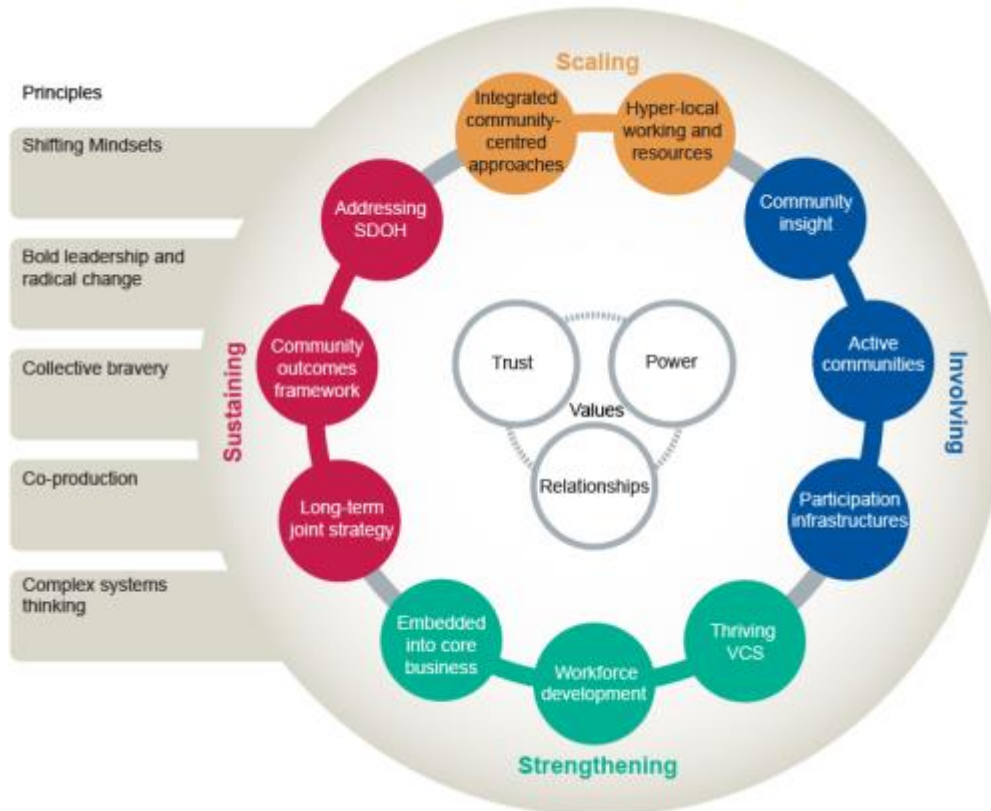
Figure 1. Example of a Health and Wellbeing Eco-system



Source: ECH Alliance (2019, <https://echalliance.com/ecosystems/>)

A further example of a system model for community-centred public health has been proposed by Public Health England (2020^{vi}). This recognises there is not one single solution to complex problems and so recommends a ‘coordinated, collaborative approach’ which operates from neighbourhood to strategic level. The model incorporates 11 key elements of change, and five principles which are ‘underpinned by core values of power, trust and relationships’, their model is demonstrated in figure 2 and table 2. Public Health England provide a series of tools to support development.

Figure 2. Eleven elements of community-centred public health: a whole-system approach



Source: Public Health England (2020)

Table 2. Eleven elements of community-centred public health

Scaling	
1.	Scaled up community-centred prevention approaches, such as integrated wellness services, social prescribing and community development. Scale is about rolling out a flexible approach that works rather than applying a standard model everywhere.
2.	Neighbourhood-based working at a ‘hyper-local’ level that taps into local resources.
Involving	
3.	Community insight work to gather stories that provide meaning to data and solutions to problems. Participatory research, especially with those who are seldom heard, can provide better understanding of people’s lives, public health needs and priorities.
4.	Active communities supported by community capacity building approaches, e.g. community development, social action or community asset transfer.
5.	Participation structures, which are vital for engagement, joint decision-making and co-production, e.g. neighbourhood forums that bring agencies and community members together.
Strengthening	
6.	A thriving voluntary, community and social enterprise sector. Growth of local capacity can be achieved through valuing the contribution of the sector and supporting volunteering.

-
7. Workforce development to build core skills and knowledge in community-centred ways of working within all prevention programmes and public service reform.
 8. Community-centred approaches used to meet all public health priorities, i.e. making it a mainstream way of working rather than a separate priority.
-

Sustaining

9. Strategic and long-term ambition for strengthening communities that is shared and communicated between agencies and communities.
 10. Community outcome frameworks with short, medium and long-term indicators on what matters to communities, such as a sense of belonging, mental wellbeing and access to local activities.
 11. Action to address the social determinants of health, such as housing, income, debt, employment, environment, crime & safety, as they directly impact on people's resilience and ability to participate.
-

Source: Public Health England (2020)

3.4 Moving forward

The Centre for Research in Health and Society (CRiHS) is part of the Institute of Health at the University of Cumbria. It is a multidisciplinary research centre that aims to contribute to the positive transformation of health and social outcomes by driving excellence in health and social research, evaluation, scholarship and practice. CRiHS focuses on inequality in each area of work, finding applied solutions to improve health and social equity, supporting everyone's equal right to thrive.

We were keen to understand the most pressing health inequalities in Cumbria and the factors driving them so that we can target our research agenda on these needs, hence the reason for this consultation. Respondents have identified a range of research they want to see undertaken.

Much of the suggested research was related to auditing provision in the county, for example:

- Mental health– which groups and which areas are most effected; what mental health provision is available, to which service users, in which locations.
- Secondary care– distance to treatment for different health conditions/socio-economic groups.
- Long term care– what is provided, to whom, and the outcomes from different types of provision
- Integrated Care Communities – commissioning practices, availability of services in different locations
- GP Practises – looking at differences in performance between practices with a stable workforce compared to those without.
- NHS Dentists – geographical and socio-economic analyses of who gets provision
- Cases taken to panels – to identify reasons and geographical differences in outcomes
- Third sector Interventions – cost-benefit analyses to show value for money against outcomes

Other suggestions included:

- Research examining the NHS funding formulae and distribution of resources
- Research to develop a better model for NHS trusts.
- Research into low educational aspiration amongst children and young people in deprived communities
- Evaluations of behavioural interventions, for example, exercise and weight loss programmes.
- Evaluations of partnership programmes delivered by organisations working together.

- Qualitative, participatory research with communities to enable their voices to be heard and facilitate understanding of the problems faced.

All of these suggestions have potential, and we would welcome collaboration; if you or your organisation would be interested in taking this work forward then please contact us to explore how we might work together. This is especially the case for the suggested audits which may be difficult to undertake without collaboration from NHS partners due to data security issues; we would welcome further discussions about this with them.

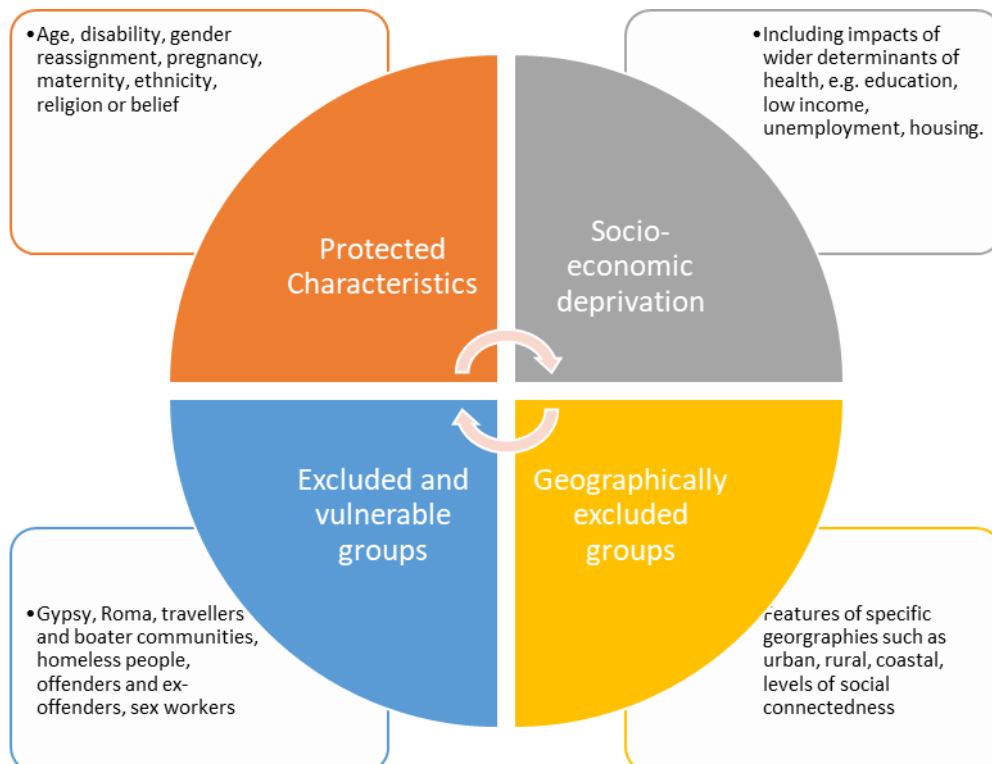
3.5 Lancashire and Cumbria Health Equity Commission (HEC)

Cumbria is included in the Health Equity Commission (HEC) for Lancashire and Cumbria which is chaired by Professor Sir Michael Marmot. The aim of the HEC is to ‘provide local organisations, partners and Integrated Care Partnerships the support to make health inequalities and the ‘prevention agenda’ our joint priority,’ with a focus on the social determinants for health. During Autumn 2021 the HEC put out a call for evidence of the needs of local partners around health inequalities and plans to present findings of this exercise in spring 2022. The findings of the HEC will also give direction to our research agenda.

3.6 Health Equity Research Group

Moreover, within CRiHS we have seven research groups which undertake a range of work into health and wellbeing, further details can be found [here](#). In addition to these we are planning to convene a Health Equity Research Group in the near future, the focus of which will be on those health inequalities that are systematically associated with social disadvantage, as illustrated in figure 3. We will welcome involvement from anyone with an interest in this area.

Figure 3. Domains of Health Inequality



Adapted from Public Health England (2021:6)^{vii}

References

ⁱ Dahlgren, G and Whitehead, M (2006) European strategies for tackling social inequities in health: Levelling up Part 2. Copenhagen: WHO Regional Office for Europe. Available at European strategies for tackling social inequities in health: Levelling up Part 2 (who.int) (date last accessed 05/10/21).

ⁱⁱ <https://www.northcumbriahealthandcare.nhs.uk/making-it-happen/integrated-care-communities-iccs/> and <https://www.morecambebayccg.nhs.uk/get-involved/integrated-care-communities>

ⁱⁱⁱ <http://www.hscboard.hscni.net/icps/about-icps/>

^{iv} <https://www.england.nhs.uk/integratedcare/what-is-integrated-care/>

^v Braveman, P. and Gruskin, S. (2003) 'Defining equity in health', *Journal of epidemiology and community health* (1979), 57(4), pp. 254–258. doi:10.1136/jech.57.4.254.

^{vi} Public Health England (2020) Community-centred public health, Taking a whole system approach - Briefing of research findings. London: Public Health England, available at https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/857029/WSA_Briefing.pdf (date last accessed 17/11/2021)

^{vii} Public Health England (2021) Addressing health inequalities through collaborative action - Briefing note. Available at

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1020977/health_inequalities_briefing.pdf (date last accessed 17/11/2021).