

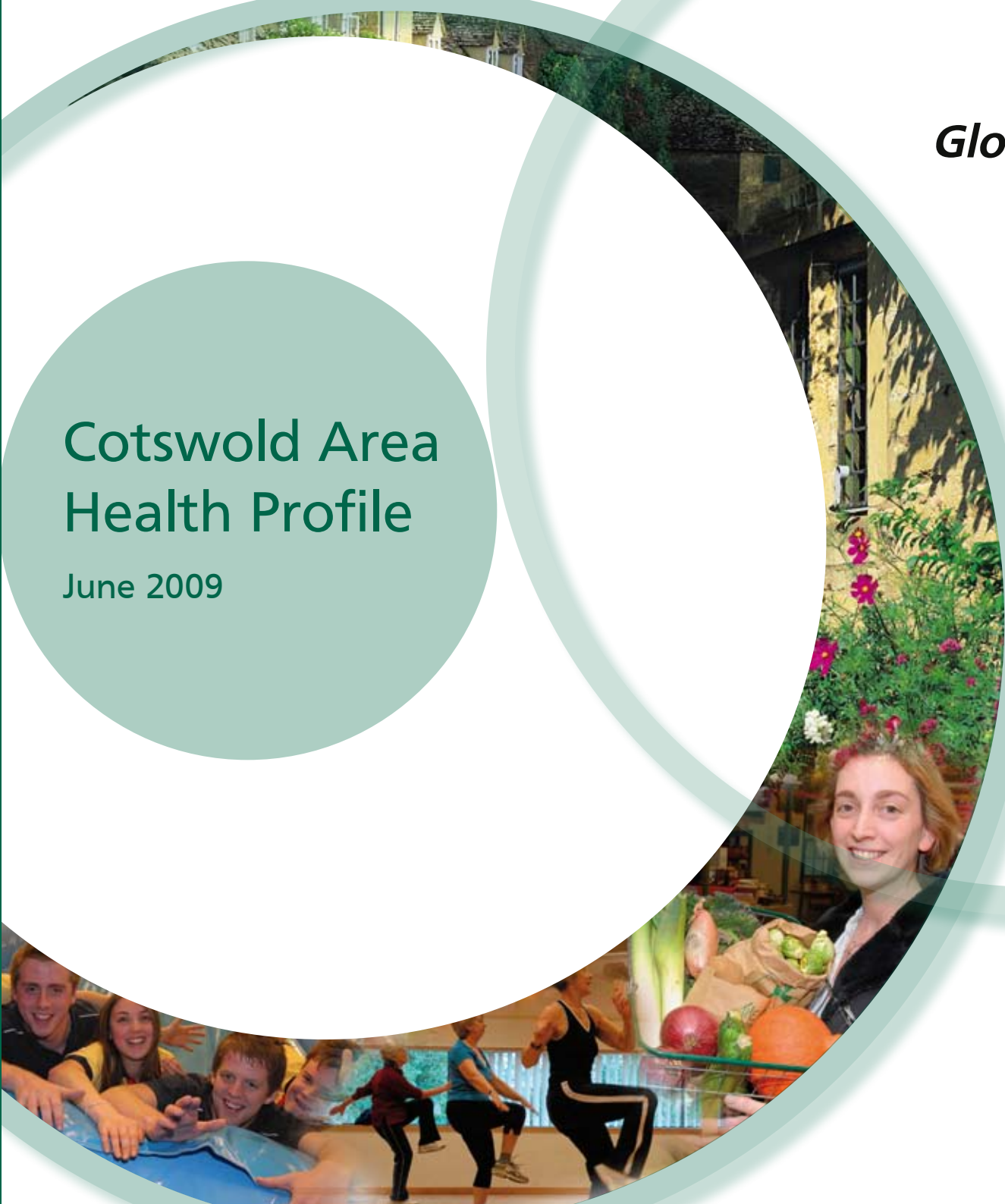
cotswold
healthy living

Cotswold Area
Health Profile

June 2009

NHS

Gloucestershire



**Gloucestershire
Conference**

1 Cotswold at a glance

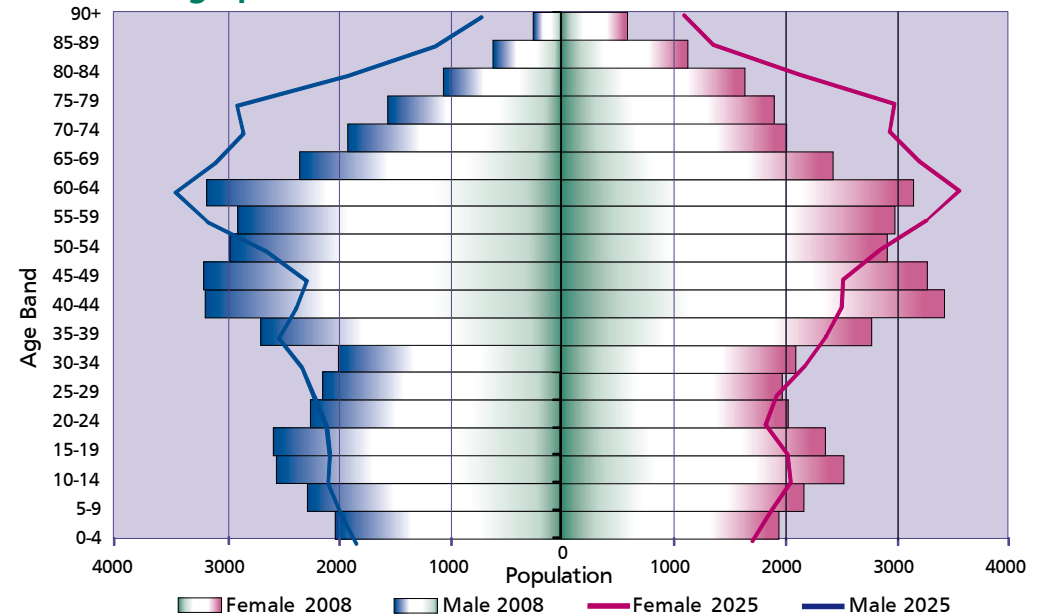
Cotswold district is a small to medium sized rural district with a population of 85,168. It covers an area of 1,165 square kilometres. Whilst only 14.3% of all Gloucestershire residents live in Cotswold district, it makes up 43.6% of the total area of the county, which demonstrates its rurality. The largest settlement is Cirencester, with around 19,000 residents. Cirencester and the eight other market towns provide a focus for much of the economic activity and public service provision within the district.

Cotswold is an affluent area with low unemployment, high educational attainment and good general health amongst its residents. Despite the overall affluence of the district, there are some pockets of relative deprivation, particularly within Cirencester and Tetbury.

Cotswold district enjoys the highest quality of life in Gloucestershire – a higher proportion of residents enjoy good general health than in the county or the country as a whole. The Cotswold Sustainable Community Strategy 2008–2012 identifies as a priority, working to maintain the quality of life and independence of older people and improving their access to services, particularly health and social care services.

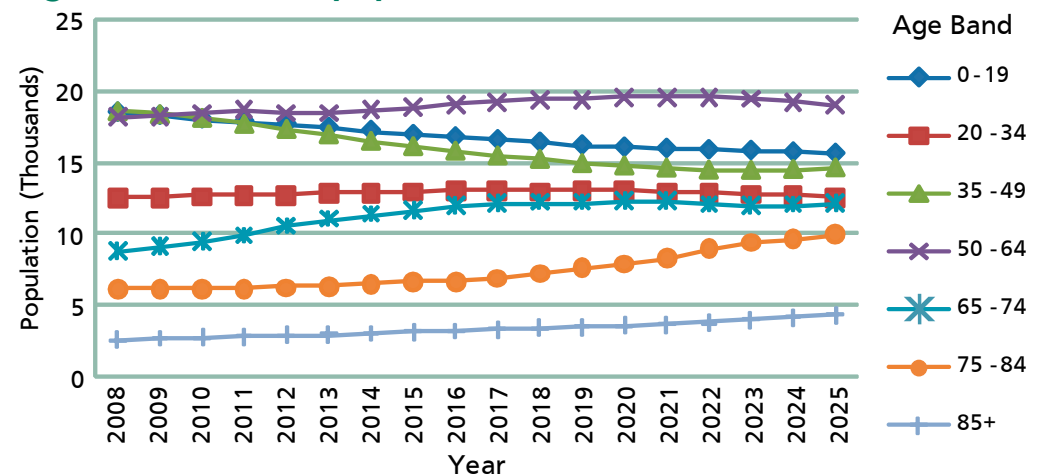
All districts in the county will have a larger population of older people by 2026, but Cotswold is projected to have the highest proportion of older people. This will mean that 30.5% of the district’s population will be aged 65 or above by 2026, compared to 24% of the projected county’s population. A corresponding dramatic reduction in the number of young people in the district is predicted, whilst overall, in the county, the figure remains relatively static. This is illustrated in Figure 1, which shows the distribution of the Cotswold population across age groups for males and females in 2008 (represented by bars) compared with 2025 (represented by the lines). Figure 2 shows similar information.

Figure 1: Cotswold population pyramid: Showing change in age profile between 2008 and 2025



Source: eJSNA data

Figure 2: Cotswold population 2008 to 2025



Source: NHS Gloucestershire Public Health Intelligence Unit 2008

Deprivation

Deprivation throughout England can be measured using the Indices of Multiple Deprivation (IMD)¹. These include 38 indicators of deprivation, such as Job Seekers Allowance households, burglary incidents, or distance of travel to primary schools.

They are contained in seven domains relating to:

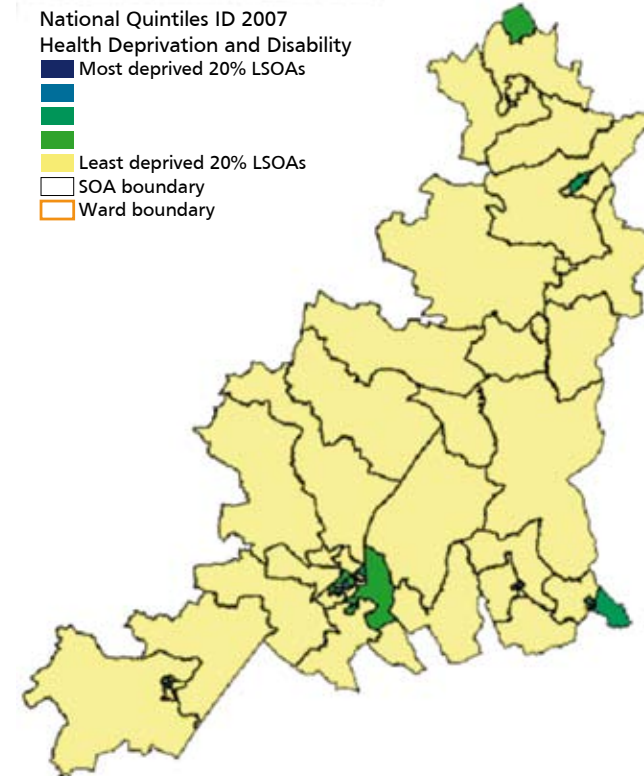
- income deprivation
- employment deprivation
- health deprivation and disability
- education, skills and training deprivation
- barriers to housing and services
- living environment deprivation
- crime.

The IMD measures the levels of deprivation that people experience within different areas of the country. This information is then used to identify areas where resources may need to be targeted.

Levels of deprivation have been measured for three different types of area throughout England. These are large administrative areas (e.g. counties and London boroughs), smaller administrative areas (e.g. districts and unitary authorities) and localised neighbourhoods called Lower Level Super Output Areas. Lower Level Super Output Areas are small geographical units (neighbourhoods) with 1,000 to 3,000 residents. They provide a more in-depth appreciation of variations in deprivation at a local level. We have used the latest IMD 2007 as a measure of multiple deprivation at this local neighbourhood level.

Figure 3 shows the 'Health Deprivation and Disability' domain of the IMD 2007 for Cotswold. This specifically measures rates of poor health, early mortality and disability and covers the entire age range. It illustrates the good health experienced by residents in Cotswold district. The IMD 2007 shows that there are no local neighbourhoods in Cotswold district that rank in the most deprived 20% of local neighbourhoods nationally.

Figure 3: Health deprivation and disability domain IMD 2007



Cotswold district is rural in character, with a dispersed population and physical access to services is a critical factor.

Figure 4 shows the 'geographical barriers' sub domain of the IMD 2007. This is one of two kinds of barriers that make up the 'Barriers to Housing and Services' sub domain of the IMD 2007. The other is 'wider barriers', which covers housing issues. The geographical barriers sub domain covers geographical access issues relating to key services including GP premises, primary schools, general stores or supermarkets and post offices.

As we can see from figure 4, much of the district experiences difficulty in accessing these services. Access to services is an issue for all those communities outside the market towns. This issue particularly affects children and young people and older people. These two age groups are prioritised through the Cotswold Sustainable Community Strategy, plus those without the financial means to afford their own transport. Addressing this barrier is essential in addressing social exclusion.

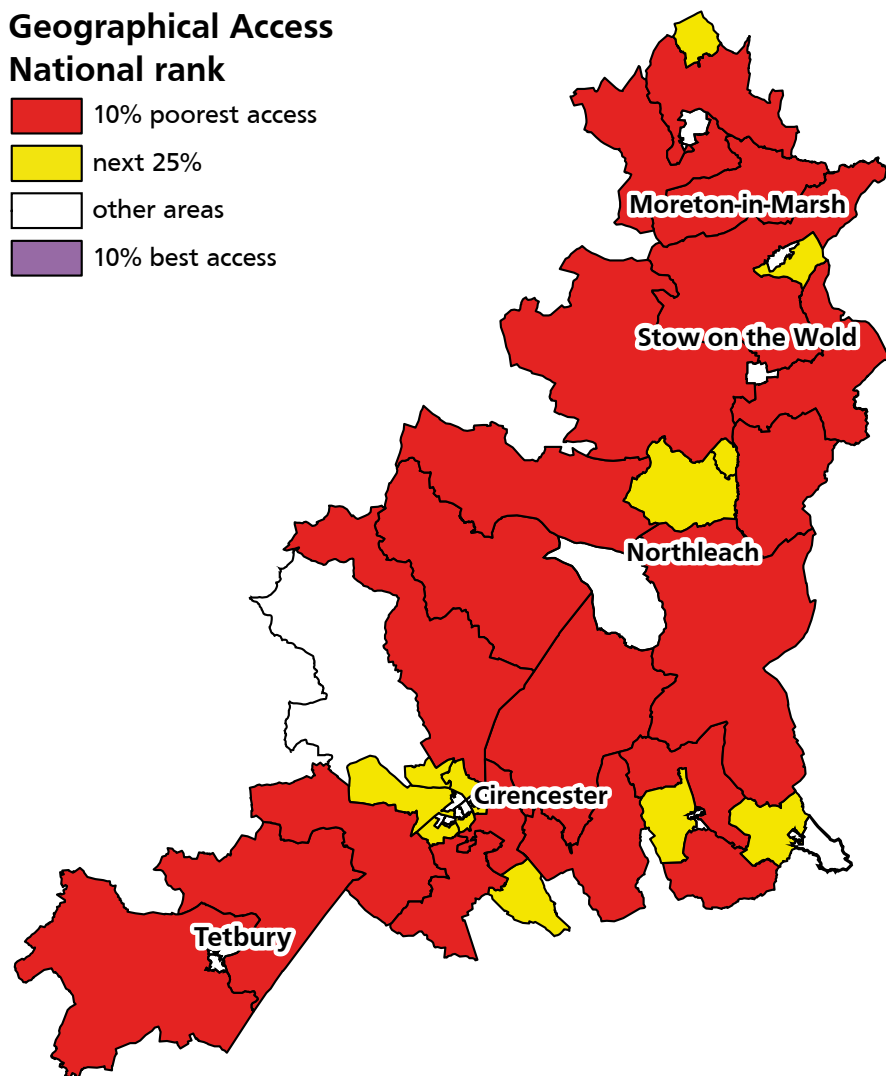
¹ See www.communities.gov.uk

Figure 4: IMD 2007 (LSOA) – Barriers to housing and services
sub domain: geographical barriers

Geographical Access

National rank

- 10% poorest access
- next 25%
- other areas
- 10% best access



2 Key issues for Cotswold

The eJSNA has identified a number of emerging issues for Cotswold in comparison with the county. These are shown in the box below.

Issues for Cotswold

- The increasing older population
- The number of lone pensioner households
- The number of road injuries and deaths
- The levels of obesity in children
- The number of people providing unpaid care

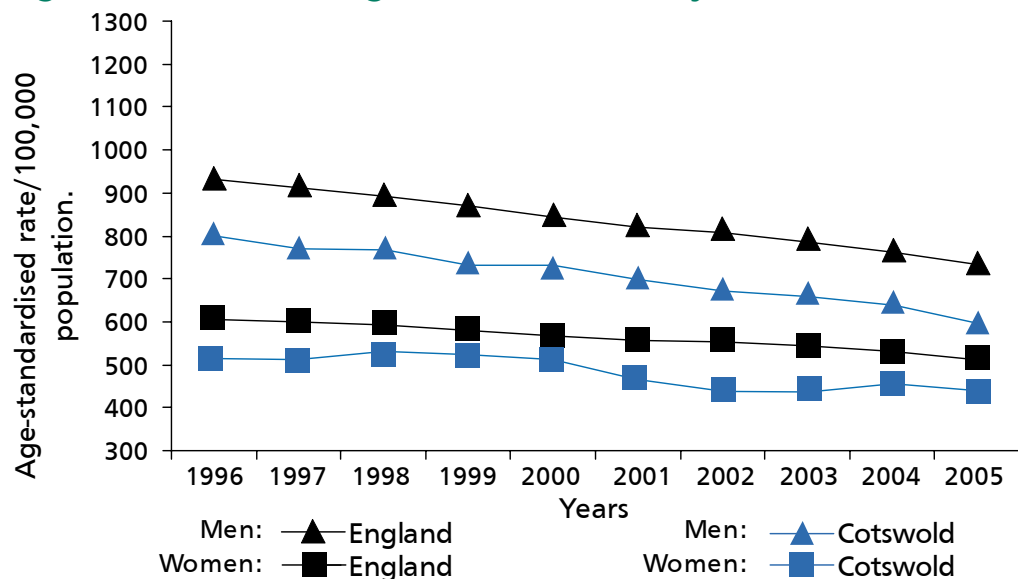
Source eJSNA



3 Morbidity and mortality

The Cotswold district has a higher proportion of residents with general good health than the rest of the county. This is reflected in figures 5 to 7 which show that all age, all cause mortality, early deaths from heart disease and stroke and early deaths from cancer are all lower than the England rate and are falling. Standardised rates have been used as these adjust for the influence of the older population in which there would be a higher number of deaths.

Figure 5: Trend 1: All age, all cause mortality



Source: APHO Profiles 2008

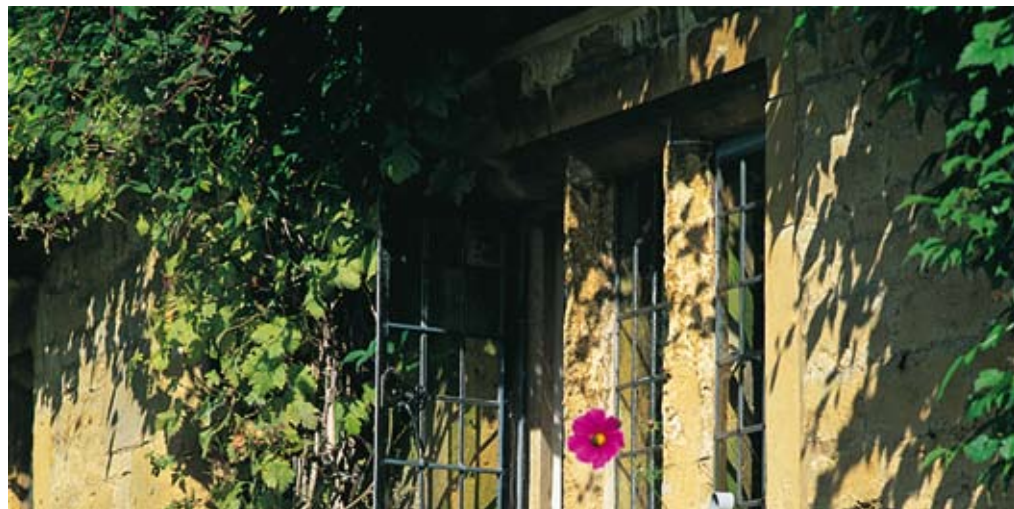
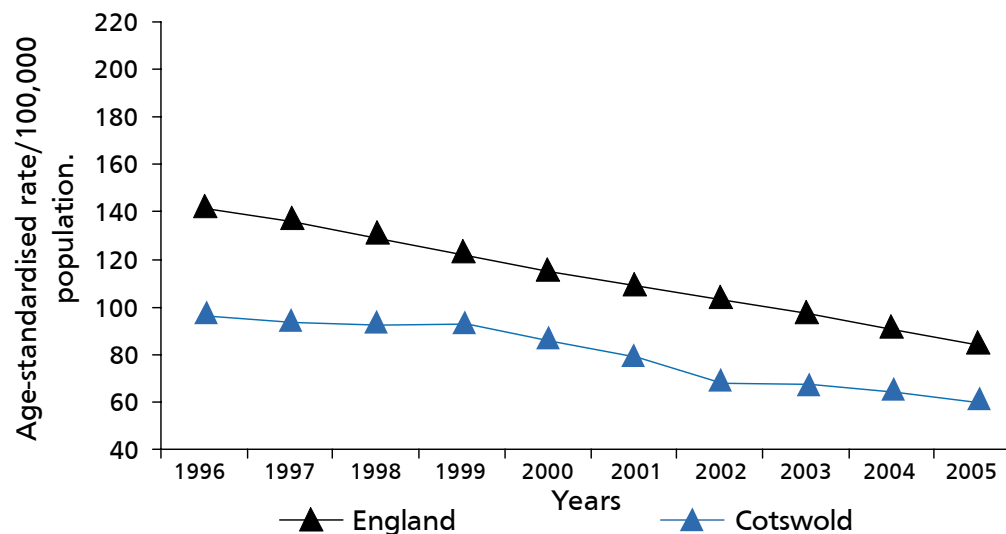
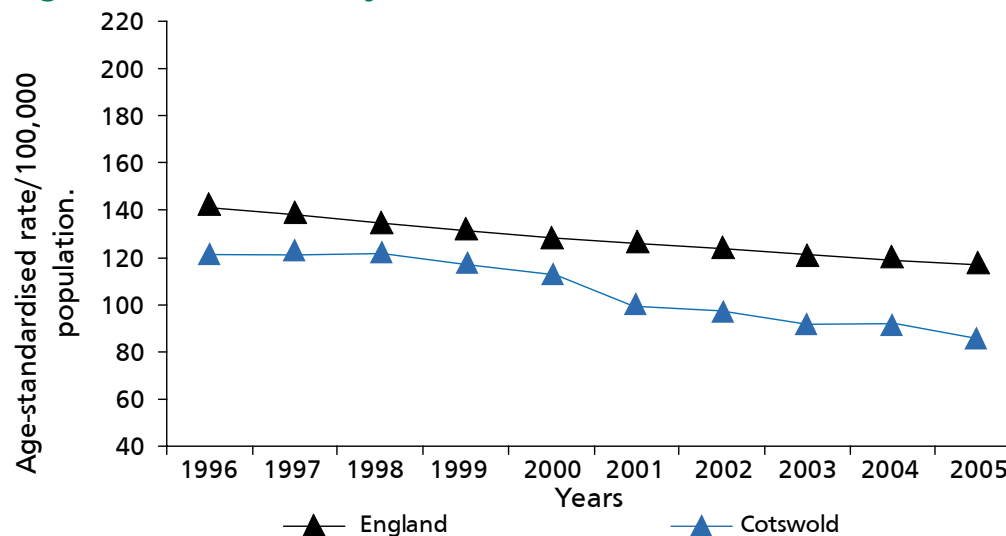


Figure 6: Trend 2: Early death rates from heart disease and stroke



Source: APHO Profiles 2008

Figure 7: Trend 3: Early death rates from cancer



Source: APHO Profiles 2008

4 Life expectancy: comparing the gap in life expectancy within Cotswold

The Association of Public Health Observatories (APHO) has developed a tool to help primary care trusts (PCTs) and local authorities to understand inequalities within their area². We have used the Health Inequalities Intervention Tool to analyse the local life expectancy gap in Cotswold district and to suggest preventive interventions that will impact on it.

Table 1 shows the absolute and relative gap in life expectancy for the most deprived fifth of areas (quintile) within Cotswold district compared to Cotswold as a whole³.

This relative gap in life expectancy is greater for males (2.7%) than for females (1.9%). The absolute gap shows that a baby boy born in the most deprived fifth of areas in Cotswold district can expect to live 2.1 years less, compared to the average expected life span of boys born in Cotswold as a whole. Similarly a girl born in the most deprived fifth of areas in Cotswold district can expect to live 1.6 years less compared to the average expected life span for girls across Cotswold district.

Table 1: Showing life expectancy at birth in years for Cotswold most deprived quintile (MDQ) and Cotswold, and the relative life expectancy gap (%), 2001-05

	Life expectancy at birth (years) Cotswold's most deprived quintile	Life expectancy at birth (years) Cotswold**	Absolute gap (years)	Relative life expectancy gap between MDQ & Cotswold*
Males	76.9	79	2.1	2.7%
Females	81.4	83	1.6	1.9%

Source LHO: Health Inequality Intervention Tool, June 2008

*The relative gap in life expectancy is the difference in life expectancy between Cotswold most deprived quintile and Cotswold district as a percentage of Life Expectancy for Cotswold district (the percentage difference). When calculated this way, a relative gap closer to 0 indicates less inequality.

** Life expectancy at birth presented in the Health Inequality Tool differs slightly from that shown in Cotswold District Profile because it is based on a different time period (2001-05 rather than 2004-06)

2 www.lho.org.uk/HEALTH_INEQUALITIES/Health_Inequalities_Tool.aspx.

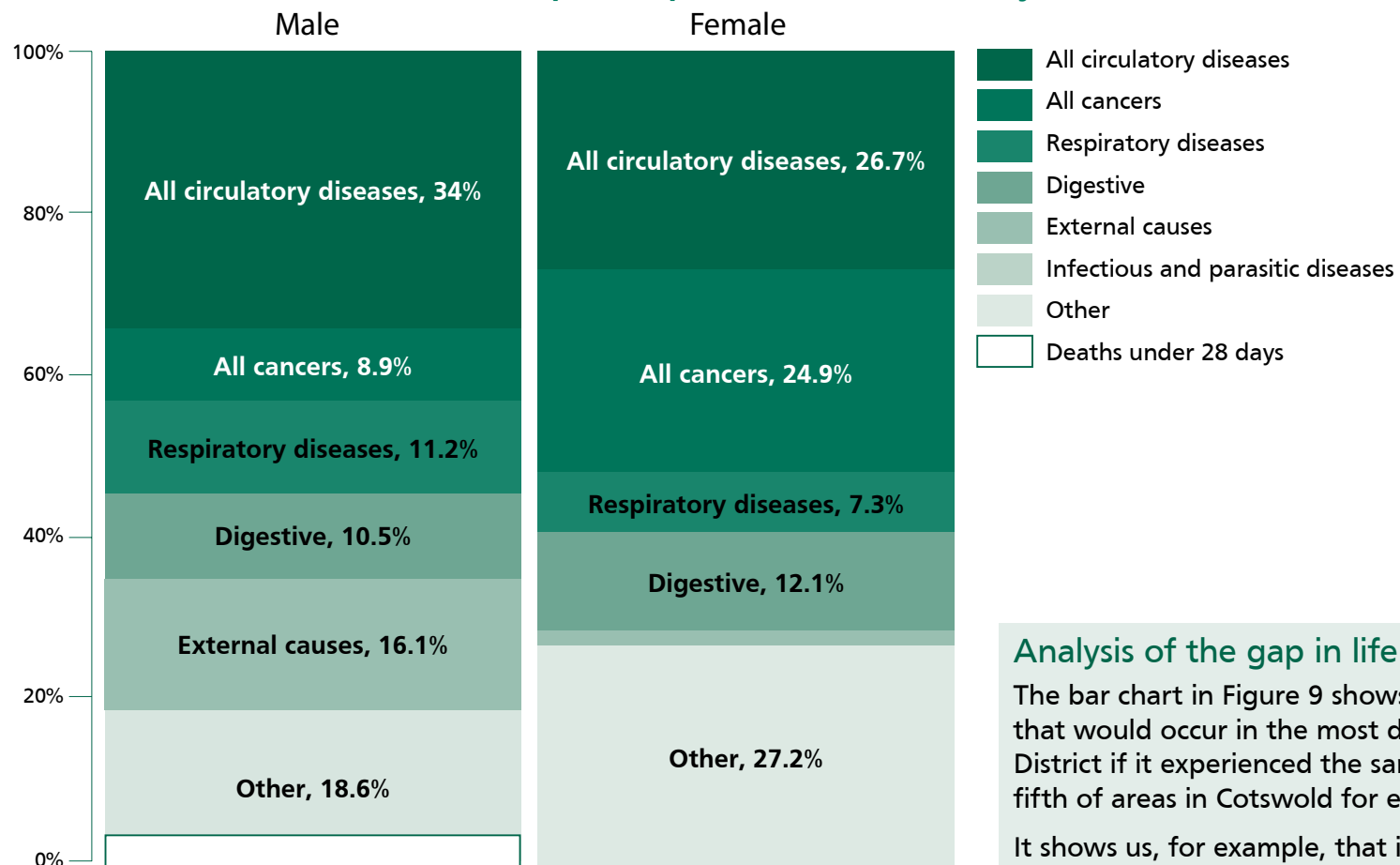
3 LHO Health Inequalities Intervention Tool

Breaking down the gap

The underlying causes of the life expectancy gap within Cotswold District are presented below as a 'scarf' chart (Figure 8). This shows the percentage contribution of various causes of death to the life expectancy gap between Cotswold district's most and least deprived quintiles⁴.

It can be seen that circulatory diseases account for a third (34%) of the gap in male life expectancy and a quarter (27%) of the gap in female life expectancy.

Figure 8: Breakdown of life expectancy gap between the most deprived quintile (MDQ) of Cotswold and the least deprived quintile in the District by cause of death



Source: London Health Observatory (LHO), June 2008

⁴ The stripes of the scarf do not include the same number of people. Deaths in younger people, especially in babies, contribute to a larger proportion of the gap as more years of life are lost.

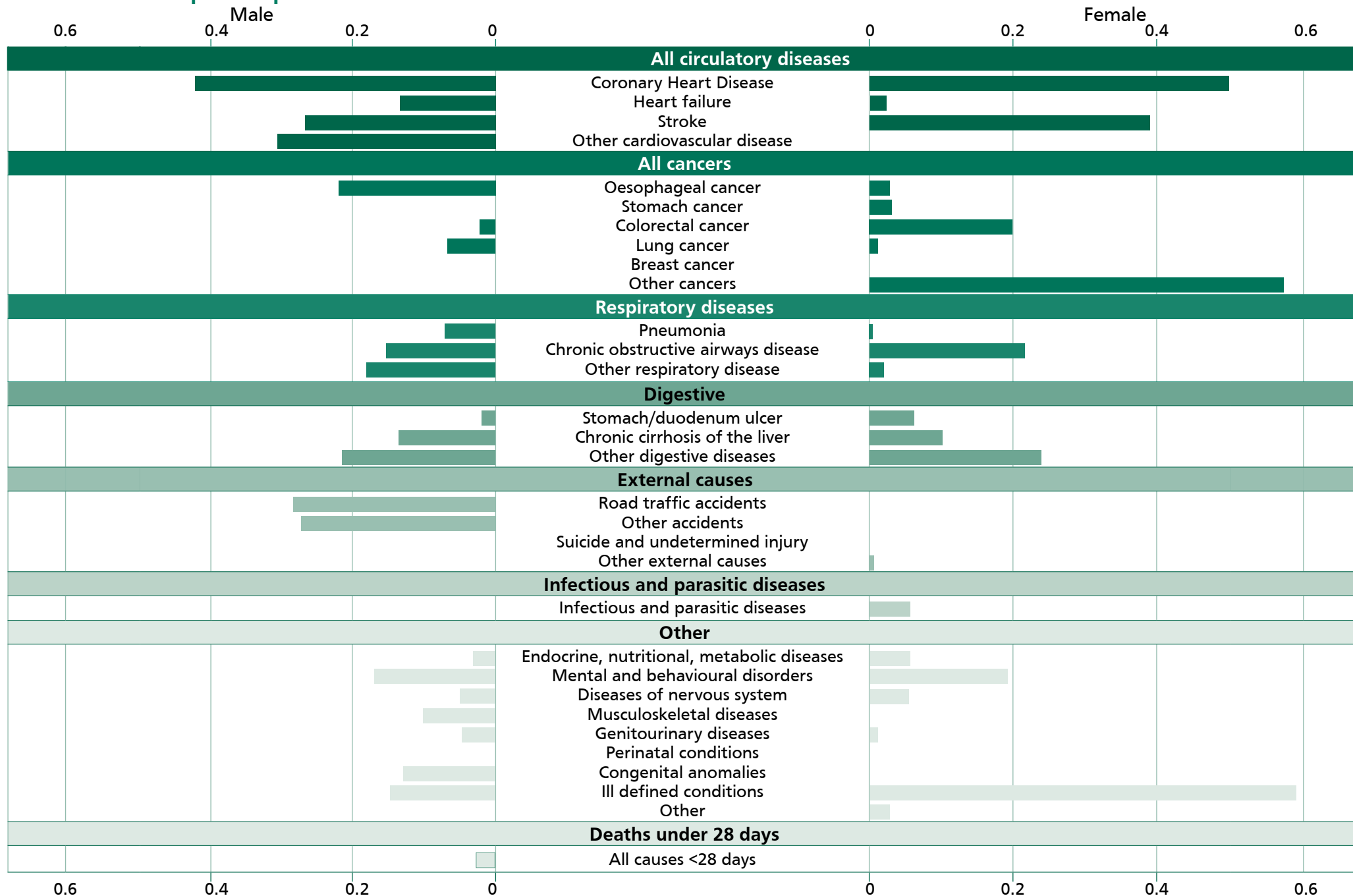


Analysis of the gap in life expectancy in Cotswold district

The bar chart in Figure 9 shows the increases in life expectancy (in years) that would occur in the most deprived fifth of areas within Cotswold District if it experienced the same mortality rate as the most affluent fifth of areas in Cotswold for each cause of death separately.

It shows us, for example, that if males in the most deprived areas in Cotswold had the same mortality rate from coronary heart disease (CHD) as males in the most affluent areas of Cotswold, they would live 0.4 years longer. It should be noted that an average population-level gain of a few months per person masks the fact that some people gain several potential years of life while others are not affected at all.

Figure 9: Life expectancy years gained if the most deprived quintile (MDQ) of Cotswold had the same mortality rate as the least deprived quintile in the District for each cause of death



Source: London Health Observatory (LHO), June 2008

Analysing the gap in life expectancy by cause of death is useful because if we can identify the key diseases that make up the gap in life expectancy within Cotswold district we can plan interventions that will have the greatest impact on reducing this gap. Figure 9 suggests that key diseases making up the life expectancy gap in Cotswold vary for males and females. This is shown in Table 2.

Table 2: Top 5 key diseases making up the gap in life expectancy within Cotswold

Males	Females
Coronary heart disease	Ill defined conditions
Other cardiovascular diseases	Other cancers
Road traffic accidents	Coronary heart disease
Other accidents	Stroke
Stroke	Other digestive diseases

These findings suggest key targeted preventive interventions that are likely to impact on the gap in male life expectancy in Cotswold district include those aimed at:

- smoking cessation
- increasing physical activity levels
- encouraging healthy eating
- raising cancer awareness
- improving independence and health and wellbeing for older people
- decreasing road traffic accidents
- accident prevention.

Key targeted preventive interventions that are likely to impact on the gap in female life expectancy in Cotswold district include those aimed at:

- smoking cessation
- encouraging healthy eating
- raising cancer awareness
- improving independence and health and wellbeing for older people.

Lifestyle choices have an important effect on an individual's risk of ill health. But choices may be influenced by wider factors such as income, unemployment, housing, and social and cultural norms. These factors may be particularly relevant when considering preventive and other initiatives in the more deprived communities.



5 What are we doing?

In October 2008, a Health Improvement Facilitator for Cotswold District was recruited by NHS Gloucestershire to work with local agencies and focus on reducing health inequalities in Cirencester and Tetbury. The post holder is based at Cotswold District Council offices in Cirencester and works very closely with the Community Development, Health and Housing Team.

Health and wellbeing activity is coordinated by the Cotswold Health and Wellbeing Partnership, hosted by Cotswold District Council. This multi-agency partnership meets quarterly to exchange information, share best practice and discuss issues for Cotswold residents. The activity of the partnership is captured in an action plan which is reviewed annually. The action plan is broken down into the ten priorities identified in the county health and wellbeing strategy, Healthy Gloucestershire, which can be seen at <http://www.gloucestershirehlp.nhs.uk/healthylivin236282.html>

The link to Cotswold Local Strategic Partnership (LSP) is www.cotswold.gov.uk

A snapshot of current successful projects includes the following:

Active and Able – mobility classes, including Tai chi, for older people. Classes are available across the whole district. This project contributes to the countywide falls prevention programme.

Development of the falls prevention pathway has continued during 2008 to ensure distributed services across the county with easy access to a wide range of falls prevention services.

These are delivered in a variety of settings to reduce the need for travel and ensure affordability. There is also a rolling programme of information events for older people to ensure services are used appropriately.

Exercise Referral

The Exercise Referral scheme has operated in the Cotswolds since 1995. It is accessible across the district via the local authority leisure centres. The scheme contributes to several priorities including tackling obesity, improving emotional health and wellbeing, improving mobility, reducing falls and accident prevention.



Befriending Service – this is led by the Churn Project and is developing a network of befrienders for older people.

North Cotswolds Drugs and Alcohol Project – this project is researching the gaps in services in the North Cotswolds and developing group and one-to-one treatments.

Play Programme Healthy Eating – Play rangers are offering free healthy snacks to children as part of the play scheme programme.

Don't Buy for Under 18s – this is a project initiated by the Cotswold Crime and Disorder Reduction Partnership, which is working with retailers to discourage them from selling alcohol to under 18s, through the use of display material and community engagement.

Indigo Project – this is a confidential young people-friendly service aimed at making healthcare accessible to young people in Cirencester. The target age group is 13 -19 year olds. It aims to provide access to existing primary

care services, health promotion and lifestyle advice in a safe setting for young people.

Look Good Feel Good sessions – this project is aimed at parents in the North Cotswolds who are identified through their children's schools and the Shape teams. The children will usually have a Common Assessment Framework (CAF). The focus of the project is to provide support for parents (usually mothers) who may have their own health issues, such as mild depression, alcohol abuse and low self esteem. The project aims to give the parents support to raise their self esteem, access appropriate healthcare services and look at their learning needs, so that they can be better prepared to support their child's learning at school.

North Cotswolds Patient Transport Service – the aim of this project is to provide a minibuss shuttle service between Moreton-in-the-Marsh Hospital and Bourton-on-the-Water Hospital, to provide patient transport, inter-hospital transfers and transport for carers who need to travel between hospitals.



6 Next steps for 2009/10

The Cotswold District has a well-deserved reputation for its work in improving services for older people. This will remain a priority in 2009-2010, with a particular focus on links to the county dementia strategy and the development of stroke services. Another high priority is support for unpaid carers. The rural nature of the district makes it extremely expensive to provide regular breaks for carers appropriate to their needs. This will be reflected in the Countywide Carers' Strategy, as there is an emphasis in the national strategy on providing breaks for carers and on supporting carers to stay mentally and physically well.

The other priorities identified in the Cotswold Sustainable Community Strategy are to:

- implement the county-wide obesity strategy
- reduce the harm caused by drugs and alcohol.

The work in these areas will be maintained to support the delivery of county-wide strategies as detailed in: www.cotswold.gov.uk/media/documents

The activity of the Health Improvement Facilitator will focus initially on working in the Watermoor ward, working closely with the Churn Project. Interventions to reduce health inequalities will focus on the key health issues identified in this profile and will include working with colleagues specialising in tobacco control, reducing smoking prevalence, reducing alcohol harm, promoting healthy eating and improving sexual health.

For further information contact:

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Appendix 1: Key statistics for Cotswold

Domain	Indicator	Number	Cotswold Rate	Glouc'shire Rate
Social Demography	Resident population, 2008 (local population projection 2008) % of total Gloucestershire population	85,168		14.3
	Geographical area (square km) % of total area of Gloucestershire	1,165		43.1
	Patients living in national most deprived quintile of neighbourhoods (Indices of Deprivation 2007) (per 1,000 registered patients)	0	0.0	79.4
	Lone parent households (self-reported at 2001 Census) (rate per 1,000 population)	1,297	37.7	51.0
	Lone pensioner households (self-reported at 2001 Census) (rate per 1,000 population)	5,755	167.2	149.3
	Overcrowded households (calculated from 2001 Census returns) (rate per 1,000 population)	1,027	29.8	45.5
	Black and minority ethnic groups, 2001 Census (% district total, county overall %)	964	1.2	2.8
Lifestyle	Estimate of adults who smoke, 2003/05 (%)	n/a	19.2	24.6
	Deaths from smoking, 2004/06 (per 100,000 population 35+)	134	159.7	191.8
	Estimated healthy eating adults, 2003/05 (%)	n/a	28.5	19.4
	Estimate of obese adults, 2003/05 (%)	n/a	22.3	24.3
	Physically active adults aged 16+, 2005/06 (%)	n/a	14.5	12.7
	Hospital stays related to alcohol, 2006/07 (directly age standardised rate per 100,000 population)	145	167.7	200.8
	Road injuries and deaths 2004/06 (crude rate/100,000 population)	53	63.7	47.3
Children and young people	Obese children in reception year, 2006/07 (%)	73	11.1	10
	Physically active children aged 5-16, 2006/07 (%)	9,894	96.8	86.8
	Teenage pregnancy 2004/06 (under 18 conception rate/1000 females)	24	16.2	30
Independent living	Independent living: Persons receiving CACD Home Care during 2006/07 (rate per 1,000 population)	657	7.9	9.3
	People providing unpaid care (self-reported 2001 Census) (rate per 1,000 population)	7,691	95.1	94.7
Older people	Falls: Over 75s admitted to hospital with a fractured femur, 2005/07 (rate per 1,000 aged over 75)	104	12.7	12.8
Morbidity and Mortality	People with limiting Long-Term Illness (self-reported 2001 Census) (rate per 1,000 population)	12,134	150.0	155.1
	Life expectancy at birth 2005/07 – male		80.6	78.7
	Life expectancy at birth 2005/07 – female		83.3	82.7
	All age all cause mortality 2005/07 (age standardised rate per 100,000 population)		490.0	542.5
	All cause mortality in under 75s, 2005/07 (age standardised rate per 100,000 population)		218.8	259.5
	Mortality rate for circulatory diseases in under 75s, 2005/07 (age standardised rate per 100,000 population)		53.0	62.2
	Mortality rate for cancer in under 75s, 2005/07 (age standardised rate per 100,000 population)		90.2	104.3
Mental Health	Outpatient first attendances: adult mental health: 2006/07 (rate per 1,000 population)	172	2.1	2.3
	Incapacity benefits for mental illness, 2006 (rate per 1,000 working population)	710	14.6	21.8

