gloucester healthy living

NHS Gloucestershire

Gloucester Area Health Profile

June 2009

Gloucestershire Conference

1 Gloucester at a glance

Gloucester city itself is one of two urban centres that lie at the heart of Gloucestershire – the other being Cheltenham town. Gloucester has an estimated population of 117,485 and a 'younger' age profile when compared to Gloucestershire as a whole. It has the highest proportion of children of all districts in the county (around 23,100 aged 0-15 years). It also has a significant number of older residents. In line with cross-county projections, the 65 plus age group is expected to increase between 2008 and 2025. This is illustrated in Figure 1, which shows the distribution of Gloucester's 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.

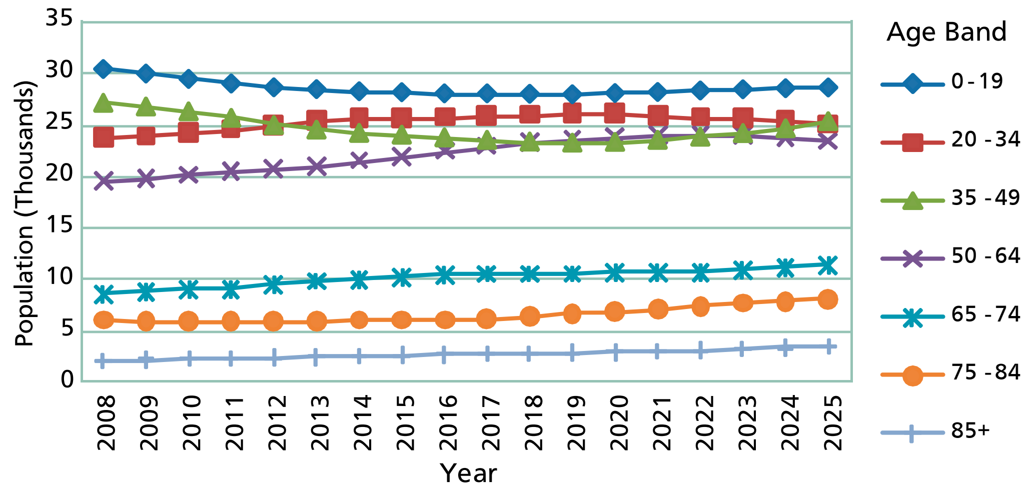
Gloucester has a higher rate of overcrowded housing and unemployment than elsewhere in the county. Around 8,200 people in Gloucester are from Black and other minority ethnic groups. This equates to 7.5% of the total population of Gloucester compared with 2.9% the of county population overall.

The Gloucester Sustainable Community Strategy 2008-2018 sets out a plan of action for a prosperous future for Gloucester and to tackle current key issues. This is set against the city's changing background of regeneration, cultural and social needs and aligns to the Local Area Agreement (LAA).

Figure 1: Gloucester Population pyramid: showing change in age profile between 2008 and 2025

Source: eJSNA

Figure 2: Gloucester population changes by age band (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.

The IMD 2007 shows Gloucester to be the most deprived district in the county, with a number of local neighbourhoods in the wards of Podsmead, Matson & Robinswood, Westgate, Barnwood, Tuffley, Moreland, Barton and Tredworth and Kingsholm and Wotton, ranking in the most deprived fifth (20%) of local neighbourhoods nationally. The overall level of deprivation in Gloucester is significantly worse than the England average.

1 See www.communities.gov.uk

There are clear links between deprivation and health, with persons living in the most deprived areas experiencing worse outcomes for a number of health-related measures such as life expectancy, mental health and incidence of cancer.

The Gloucestershire Story 2008 outlines some of these inequalities (See below).

Some examples of inequalities in Gloucestershire:

- Rates of prevalence of coronary heart disease are twice as high in our most deprived communities as in our least deprived, as are rates of chronic obstructive pulmonary diseases (bronchitis/emphysema).
- Our most deprived communities spend 50% more per person per week on tobacco than do our least deprived communities.
- Young adults from our most deprived communities are much more likely than other young adults in the county to leave school with no work, education or training destination.
- Infants and young children from our most deprived communities are twice as likely as those from our least deprived communities to be admitted to hospital in an emergency.
- Birth rates are almost 40% higher in our most deprived communities than in our least deprived, with low birth weight babies almost 50% more common.
- Residents of our most deprived communities are significantly more likely than other Gloucestershire residents to experience anti-social behaviour in their neighbourhoods.
- People who live in our most deprived neighbourhoods are much more likely than other residents of the county to become victims of a recorded crime.

Source: Gloucestershire Story 2008

Figure 3 shows the 'Health deprivation and disability' domain of the IMD 2007 for Gloucester.

Figure 3: IMD 2007 (Gloucester LSOAs) – Health deprivation and disability domain

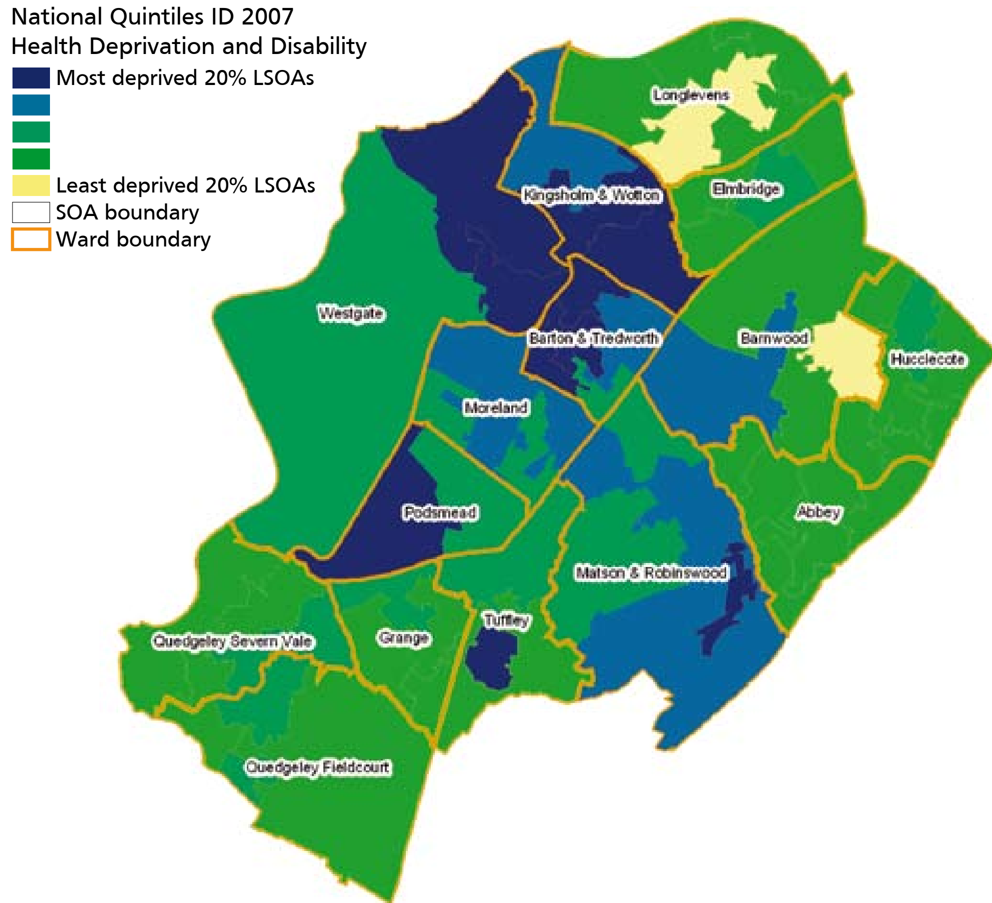
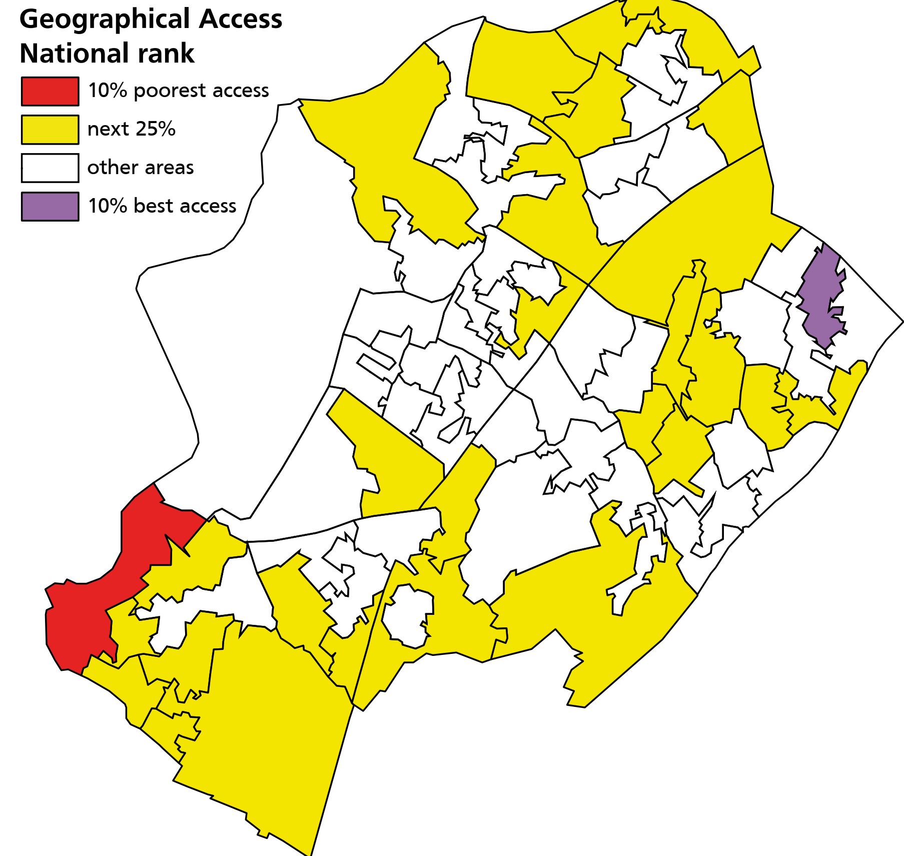


Figure 4 shows the ‘Barriers to Housing and Services’ domain of the IMD 2007. The indicators are structured into two sub-domains: ‘geographical barriers’ and ‘wider barriers’, that include issues relating to access to health services, post offices and housing. As Gloucester is a largely urban area, only a small part of the Quedgely Severn Vale Ward falls in the ten per cent nationally with poorest access. Areas close to the city centre are generally well provisioned, though access appears to decrease slightly as we move towards the periphery of the city.

Over recent years, health needs assessments have been conducted for the areas of Matson, Barton, White City and Tredworth and these have helped to produce targeted recommendations for problems specific to our most deprived areas.

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



2 Key issues for Gloucester

Gloucester has arguably the greatest need of all the districts in the county for health improvement. This is demonstrated through the number of key issues identified through the JSNA in comparison with other districts. (Appendix 1.)

Issues for Gloucester

- The most deprived district in Gloucestershire
- The number of lone parent households
- The number of overcrowded households
- Lower life expectancy in males and females than the county average
- The rates of premature death from circulatory diseases
- The rates of premature death from cancer
- Levels of healthy eating in adults
- Levels of physical activity in adults
- The rates of hospital admission related to alcohol
- Levels of physical activity in children
- Levels of teenage pregnancy
- The number of adults who smoke
- The number of deaths from smoking
- Levels of mental illness

Source: eJSNA

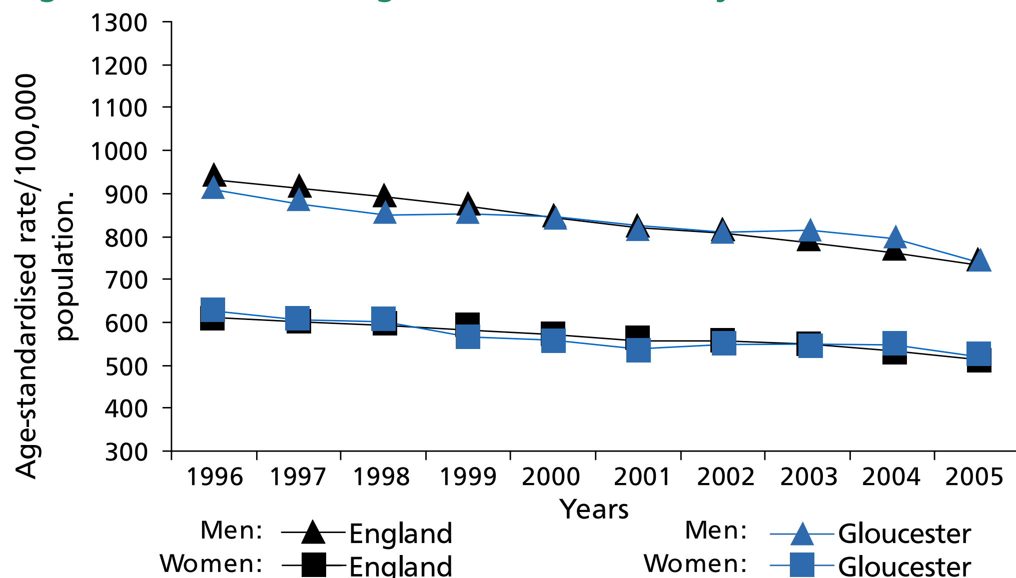
Many initiatives are already underway, or planned, to help tackle the identified issues. However, there are also gaps where further work needs to be undertaken. Working in partnership with a number of key agencies will be vital for continued success and delivery of new schemes. Section 5 provides examples of multi-agency groups/initiatives working to improve the health of people in Gloucester.

3 Morbidity and mortality

Across the county, Gloucester has the lowest life expectancy at birth (LEB) for females (81.8 years) compared to 82.7 for Gloucestershire and the highest all age, all cause mortality rate (Figure 5).

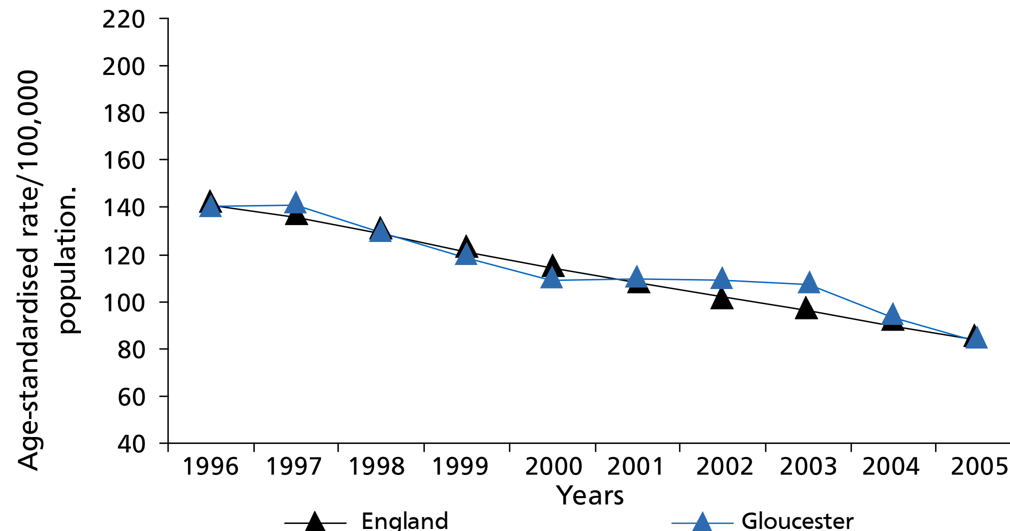
Gloucester has the highest rate in the county of early deaths from heart disease and stroke. However, these have been falling since 1996 at a similar rate to that of England (Figure 6). Early death rates from cancer appear not to have declined since 2001 (Figure 7). This suggests a need for interventions to raise cancer awareness and encourage screening and early detection. 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



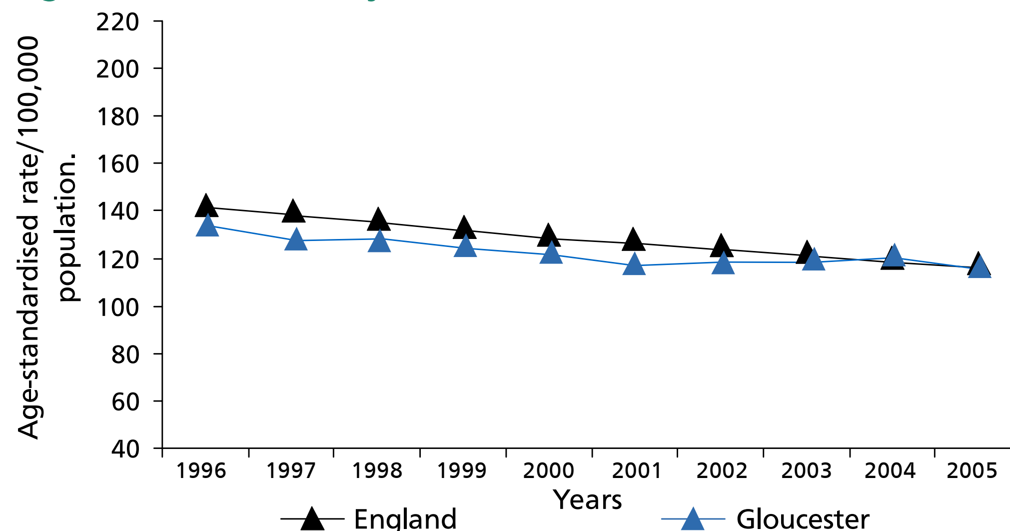
Source: APHO Health Profiles 2008

Figure 6: Trend 3. Early death rates from heart disease and stroke



Source: APHO Health Profiles 2008

Figure 7: Trend 2. Early death rates from cancer



Source: APHO Health Profiles 2008

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

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 area. We have used the Health Inequalities Intervention Tool to analyse the local life expectancy gap in Gloucester and to suggest preventive interventions that will impact on the life expectancy gap within Gloucester and save many years of life for Gloucester residents.

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

The relative gap in life expectancy between Gloucester's most deprived quintile and Gloucester district as a whole is greater for males (7.3%) than for females (3.8%). The absolute gap shows that a baby boy born in the most deprived fifth of areas in Gloucester can expect to live 5.5 years less compared to the average expected life span of baby boys born in Gloucester district as a whole. Similarly a girl born in the most deprived fifth of areas within Gloucester can expect to live 3.1 years less compared to the average expected life span for girls across Gloucester district as a whole.

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

	Life expectancy at birth (years) Gloucester Most deprived Quintile	Life expectancy at birth (years) Gloucester **	Absolute gap (years)	Relative life expectancy gap between MDQ & Gloucester *
males	70.7	76.2	5.5	7.3 %
females	78	81.1	3.1	3.8%

Source LHO: Health Inequality Intervention Tool June 2008

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

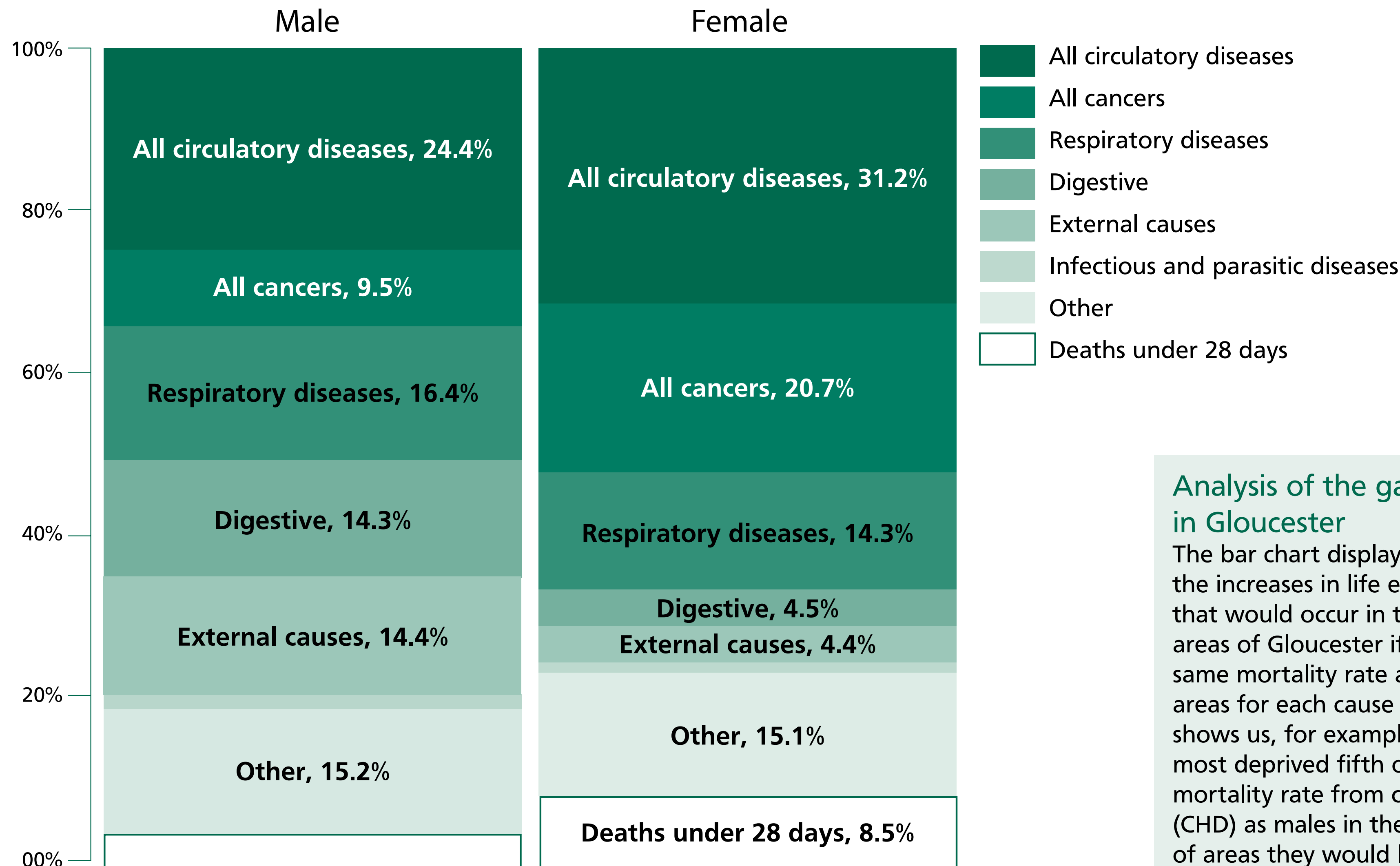
*** Life expectancy at birth presented in the Health Inequality Tool differs slightly from that shown in Gloucester City Profile because it is based on a different time period (2001 -05 rather than 2004-06)*

Breaking down the gap

The underlying causes of the life expectancy gap within Gloucester are presented as a 'scarf' chart in figure 8. This shows the percentage contribution of various causes of death to the life expectancy gap between Gloucester's most and least deprived quintiles.

It can be seen that circulatory diseases account for around a quarter (24.4%) of the gap in male life expectancy and nearly a third (31.2%) of the gap in female life expectancy within Gloucester. Figure 8 also shows us, for example, that eliminating excess deaths from circulatory diseases and cancers in women would halve the gap in female life expectancy within Gloucester.

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



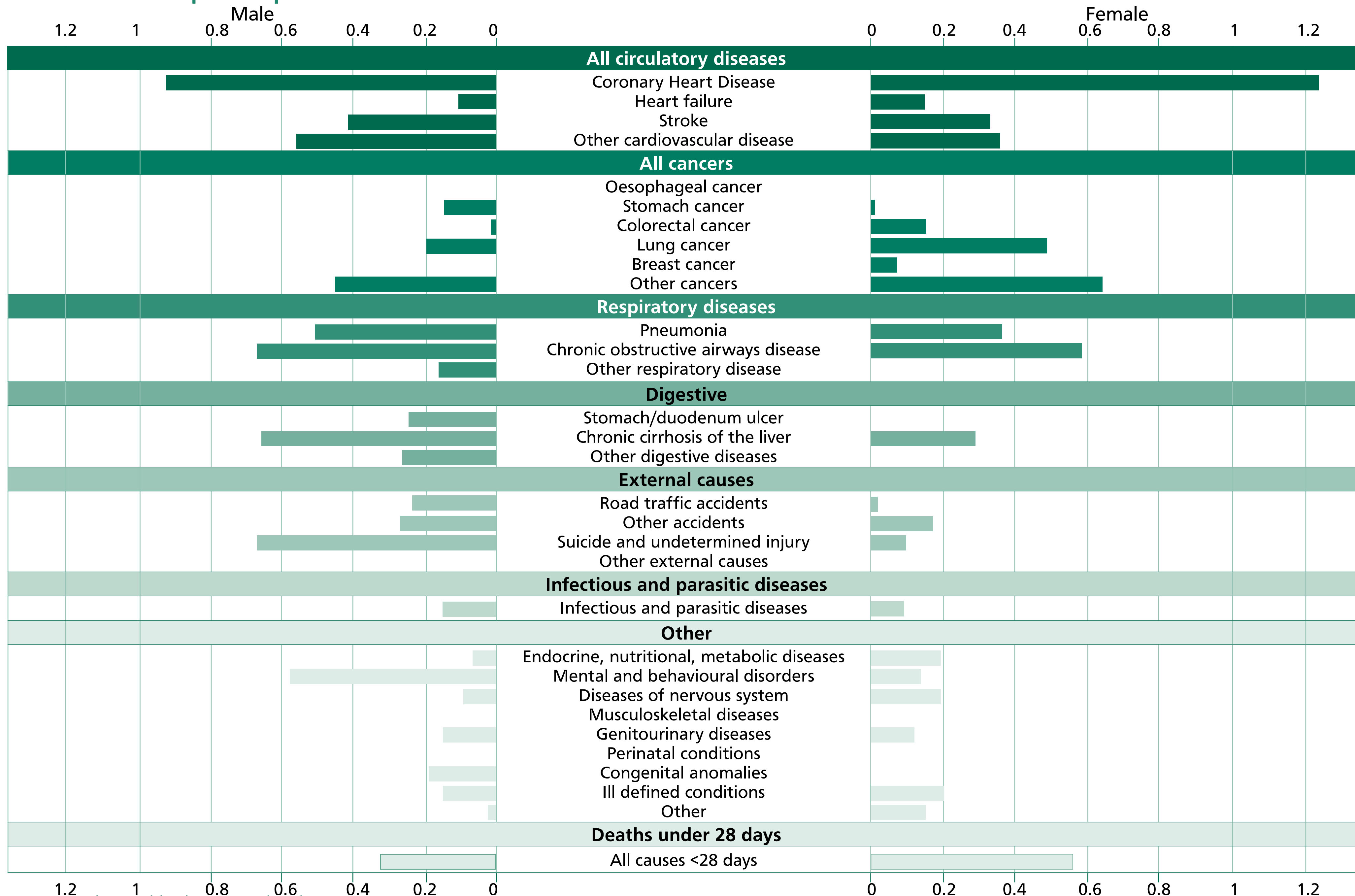
Source: London Health Observatory (LHO) June 2008

Analysis of the gap in life expectancy in Gloucester

The bar chart displayed in figure 9 shows the increases in life expectancy (in years) that would occur in the most deprived areas of Gloucester if they experienced the same mortality rate as the most affluent areas for each cause of death separately. It shows us, for example, that if males in the most deprived fifth of areas had the same mortality rate from coronary heart disease (CHD) as males in the least deprived fifth of areas they would live 0.9 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. Reducing health inequalities would save many years of life for Gloucester residents.

5 I.e. the charts show those diseases where the most deprived quintile has a greater mortality rate than the selected comparator. The charts only show diseases where there is excess mortality in the most deprived quintile of the local authority in relation to the comparator. If there is no (or negative) excess mortality, no bar is shown on the charts.

Figure 9: Life expectancy years gained if the most deprived quintile (MDQ) of Gloucester 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 Gloucester we can plan interventions that will have the greatest impact on reducing this gap, while saving years of life. Figure 9 suggests that key diseases making up the life expectancy gap in Gloucester vary for males and females. This is shown in Table 2.

Table 2: Key diseases making up the gap in life expectancy within Gloucester

Males	Females
Coronary Heart Disease	Coronary Heart Disease
Chronic obstructive airways disease	Other cancers
Suicide & undetermined Injury	Chronic obstructive airways disease
Chronic cirrhosis of the liver	Deaths under 28 days
Mental & behavioural disorders	Lung cancer

The above findings suggest key targeted preventive interventions that are likely to impact on the gap in male life expectancy in Gloucester and save years of life for men include those aimed at:

- smoking cessation
- increasing physical activity levels
- encouraging healthy eating
- reducing alcohol misuse
- suicide prevention
- improving mental health

Key targeted preventive interventions that are likely to impact on the gap in female life expectancy in Gloucester and save years of life for women include those aimed at:

- smoking cessation
- increasing physical activity levels
- encouraging healthy eating
- raising cancer awareness
- reducing teenage pregnancy
- increasing early access to maternity services
- promoting breast feeding

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?

Health Improvement Facilitator

The Health Improvement Facilitator role began as a partnership between Community Counts and West Gloucestershire Primary Care Trust (now NHS Gloucestershire). The focus of the work was to coordinate existing services, address duplication, identify gaps and amend mainstream provision in the Neighbourhood Management area of Barton, Tredworth and White City. The aim was that a more knowledgeable, skilled and confident community would therefore be empowered to change their lifestyle behaviours to reduce coronary heart disease, stroke, diabetes and cancer, through giving up smoking, eating a healthier diet, managing their weight and being more physically active.

Due to its success, the Health Improvement Facilitator role has been mainstreamed by NHS Gloucestershire. The current post holder is based at Herbert Warehouse and works very closely with departments across the council, health and social care, as well as voluntary and community groups. The work has expanded beyond the original Neighbourhood Management area and now covers the whole of the Gloucester Locality.

Key achievements this year have included the launch of Fresh Start 4 Life based at Podsmead. This is a programme of activities to help people aged 50+ to eat well, move more and live longer. Sessions have included Tai Chi, Wii Sports, Indian head and hand massage and healthy eating advice.

Healthy City Partnership

A key function of the group is to deliver on health-related outcomes set out in the Sustainable Community Strategy for Gloucester 2008-18. One way of achieving this has been the allocation of funding through the Small Grants Application Scheme to a number of community-based projects aimed at improving health. Examples of schemes funded are: a culturally sensitive health programme for Bangladeshi women, delivered in a community café (Gloucester has the second highest proportion of black and minority ethnic residents in the South West, exceeded only by Bristol); and an orienteering project for all age groups and abilities based at Gloucester Park.

Future priorities for the group will be to focus on schemes increasing access to healthy affordable food and to develop further tobacco control initiatives.

The Healthy City Partnership is a sub-group of The Gloucester Strategic Partnership providing regular updates on progress towards achieving the health-related outcomes set out in the Sustainable Communities Strategy. The Gloucester Strategic Partnership brings together partners from the public, private and the voluntary and community sectors, who are all interested in improving social, economic and environmental aspects of Gloucester.

Mapping exercise

Funding has been made available to conduct a mapping exercise to identify current physical activity opportunities in Gloucester and to appoint a physical activity and walks coordinator to address identified gaps and set up community walking groups.

Stop Smoking Shop

Premises were acquired before Christmas 2008 for the delivery of a stop smoking service accessible to city centre shoppers on a drop-in basis. The shop has proved extremely successful with groups that are not usually seen in more traditional programmes accessing services. It is hoped that the shop lease can be extended and it has been suggested that a rolling programme of health-related services could be offered from the premises.

Health Trainers programme

This is a national initiative which will train members of the community to deliver health advice through one-to-one sessions and the provision of personalised plans. The Health Trainers Coordinator is now in place and is beginning to roll the programme out in Gloucester - initially in Matson, Barton & Tredworth and Podsmead. Six Health Trainers have been recruited and will be trained in the Autumn.

Living and Learning Centre

The Living and Learning Centre (L&LC) delivers a range of programmes aimed at increasing access to information and opportunities that help to improve the quality of life of people in Gloucester and the surrounding districts. The project is led by a partnership that includes Gloucester City Council, NHS Gloucestershire and the University of Gloucestershire. Ongoing programmes and recent activities include:

- **Fresh Start scheme** – adult exercise referral programme
- **Get Fit for Success** – fun physical activity and healthy lifestyles advice for young school children who have disengaged with traditional PE
- **Tea dances** – access to L&LC staff and advice whilst engaging in physical and social activity.

During 2009-10, the Living & Learning Centre will continue to focus on delivering projects that provide general information on healthy eating, physical activity, smoking, sexual health, mental health and falls prevention, as well as offering support to make healthier lifestyle changes.

Substance Action Group

The Gloucester Substance Action Group has been working to reduce alcohol harm, including: violent crime (for which Gloucester has a rate significantly worse than the England average); hospital admissions; and binge drinking.

The group has run a number of campaigns and initiatives, for example: a city centre street stall providing information to young people; a DVD campaign in pubs at Christmas, advocating sensible drinking messages; and lanyards for young people displaying contact numbers for substance misuse services. It is rolling out a 'Don't Buy For Under 18s' campaign at local supermarkets in Spring 2009, which has proved successful elsewhere in the county. In terms of future needs to take forward the harm reduction agenda, the group has identified the following:

- better information sharing systems between organisations
- campaigns produced in DVD format - these appear to gain more attention than traditional poster formats
- production of good practice toolkits for initiatives that have worked well elsewhere.

6 Next steps for 2009/2010

1. Interventions to improve the health of Gloucester residents will need to include a focus on the wider determinants of health, including:
   - deprivation
   - employment
   - housing
   - the environment
2. Healthy lifestyle interventions should be evidence-based and culturally appropriate, focussing on:
   - smoking
   - obesity
   - sexual health
   - alcohol and substance misuse
3. Promoting cancer awareness, mental health and social inclusion will be a priority for Gloucester.
4. Services should focus on targeting areas of Gloucester with greatest deprivation and groups experiencing worse health outcomes (including: those living in areas of deprivation; black and other ethnic minority communities; older people; homeless people; and those with mental health problems). A concerted effort to tackle health inequalities in Gloucester will save years of life.
5. The activity of the Health Improvement Facilitator 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.

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Appendix 1: Key statistics for Gloucester

Domain	Indicator	Number	Gloucester City Rate	Gloucestershire Rate
Social demography	Resident population, 2008 (local population projection 2008) % of total Gloucestershire population	117,485	19.7	
	Geographical area (square km) % of total area of Gloucestershire	41	1.5	
	Patients living in national most deprived quintile of neighbourhoods (IMD 2007) (per 1,000 registered patients)	31,167	257.3	79.4
	Lone parent households (self-reported at 2001 Census) (rate per 1,000 population)	3,144	68.7	51.0
	Lone pensioner households (self-reported at 2001 Census) (rate per 1,000 population)	6,234	136.2	149.3
	Overcrowded households (calculated from 2001 Census returns) (rate per 1,000 population)	2,728	59.6	45.5
	Black and Minority Ethnic Groups 2001 Census (% district total, county overall %)	8,193	7.5	2.9
Lifestyle	Estimate of adults who smoke 2003/05 (%)	n/a	26.5	24.6
	Deaths from smoking 2004/06 (rate/100,000 population 35+)	188	232.1	191.8
	Estimated healthy eating adults, 2003/05 (%)	n/a	23.2	19.4
	Estimate of obese adults, 2003/05 (%)	n/a	24.1	24.3
	Physically active adults aged 16+, 2005/06 (%)	n/a	10.2	12.7
	Hospital stays related to alcohol, 2006/07 (directly age standardised rate per 100,000 population)	303	266.1	200.8
	Road injuries and deaths 2004/06 (crude rate per 100,000 population)	36	31.8	47.3
Children and young people	Obese children in reception year, 2006/07 (%)	96	10.2	10
	Physically active children aged 5-16, 2006/07 (%)	11,926	81.3	86.8
	Teenage pregnancy 2004/06 (under 18 conception rate/1000 females)	106	45.3	30
Independent living	Independent living: Persons receiving CACD Home Care during 2006/07 (rate per 1,000 population)	1,093	9.7	9.3
	People providing unpaid care (self-reported 2001 Census) (rate per 1,000 population)	10,413	86.0	94.7
Older people	Falls: Over 75s admitted to hospital with a fractured femur 2005/07 (rate per 1,000 over 75s)	103	11.9	12.8
Morbidity and mortality	People with limiting Long-Term Illness (self-reported 2001 Census) (rate per 1,000 population)	18,531	153.0	155.1
	Life expectancy at birth 2005/07 – male		77.9	78.7
	Life expectancy at birth 2005/07 – female		81.8	82.7
	All age all cause mortality 2005/07 (age standardised rate per 100,000 population)		595.6	542.5
	All cause mortality in under 75s 2005/07 (age standardised rate per 100,000 population)		299.4	259.5
	Mortality rate for circulatory diseases in under 75s 2005/07 (age standardised rate per 100,000 population)		76.2	62.2
	Mortality rate for cancer in under 75s 2005/07 (age standardised rate per 100,000 population)		114.3	104.3
Mental Health	Outpatient first attendances: adult mental health: 2006/07 (rate per 1,000 population)	408	3.4	2.3
	Incapacity benefits for mental illness, 2006 (rate per 1,000 working population)	2,040	29.0	21.8

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Published by NHS Gloucestershire 2009