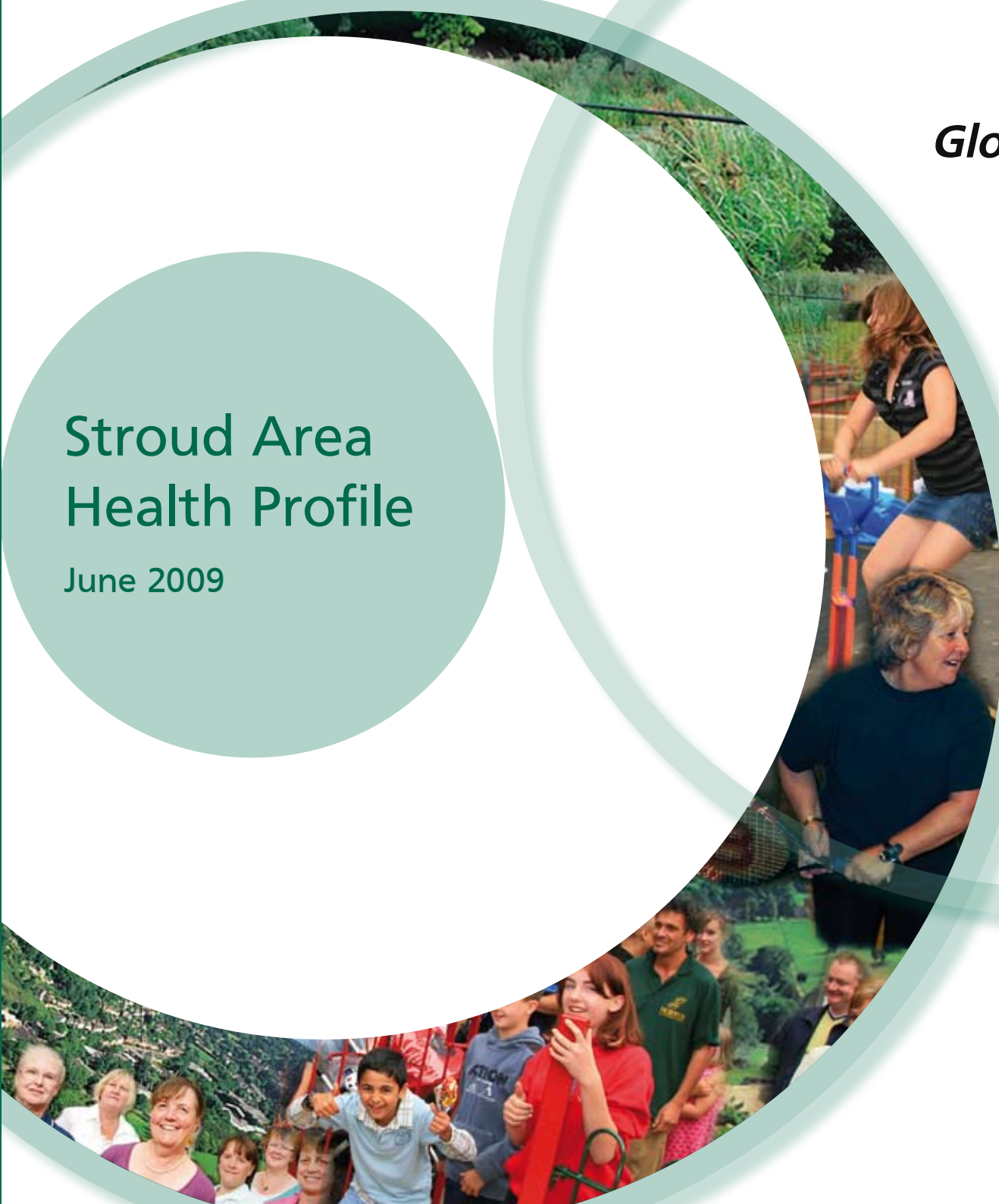


stroud healthy living

Stroud Area Health Profile

June 2009



NHS

Gloucestershire



Gloucestershire
Conference

1. Stroud¹ at a glance

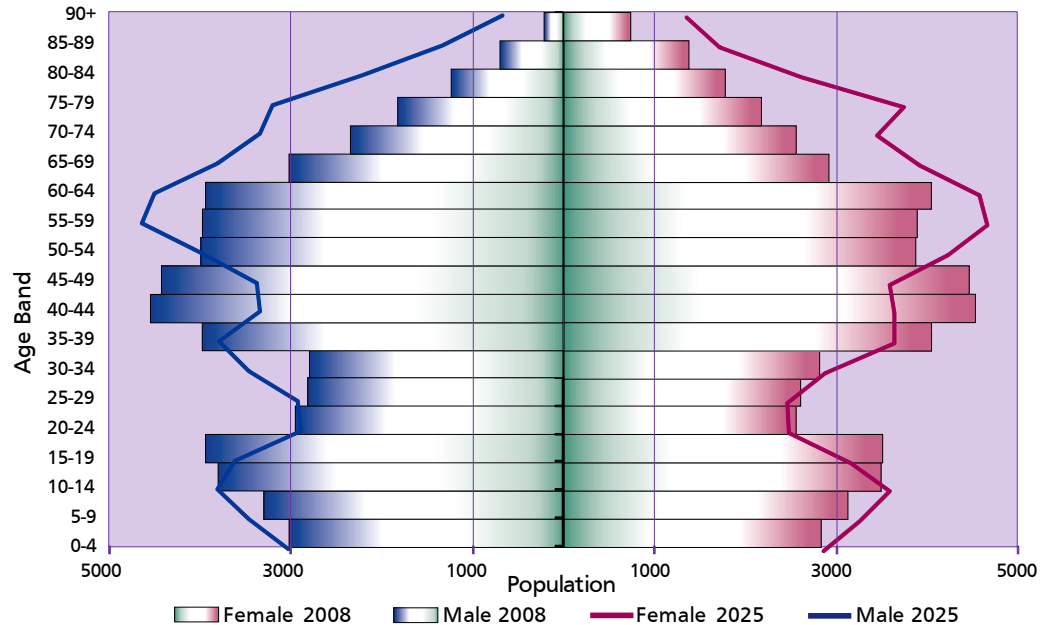
Stroud district is located in a predominately rural setting, with five small town centres in Stroud, Dursley, Nailsworth, Berkley and Wotton-under-Edge. Stroud has good health indicators and a safe and clean environment. It has low unemployment, offers good educational opportunities and has a housing affordability comparable to the national average ratio. The health inequalities gap within Stroud is small, relative to other districts in Gloucestershire.

An estimated 114,203 people live in Stroud. Approximately 40,000 of Stroud's population live in urban settings. According to the census 2001, there are fewer than 1,500 people from Black and ethnic minority groups living in Stroud (1.3% of the Stroud population).

The population of Stroud is expected to follow national trends with a significant growth in older people. Figure 1 shows the distribution of the Stroud population across age groups for males and females in 2008 (represented by bars) compared with 2025 (represented by the lines). Specifically, the group age 50 and over is expected to increase in the next 17 years with a sharp increase in the group age 75-84. The age group 10-24 is expected to decrease by around 3,000. Figure 2 shows similar information, presented as trends over time.

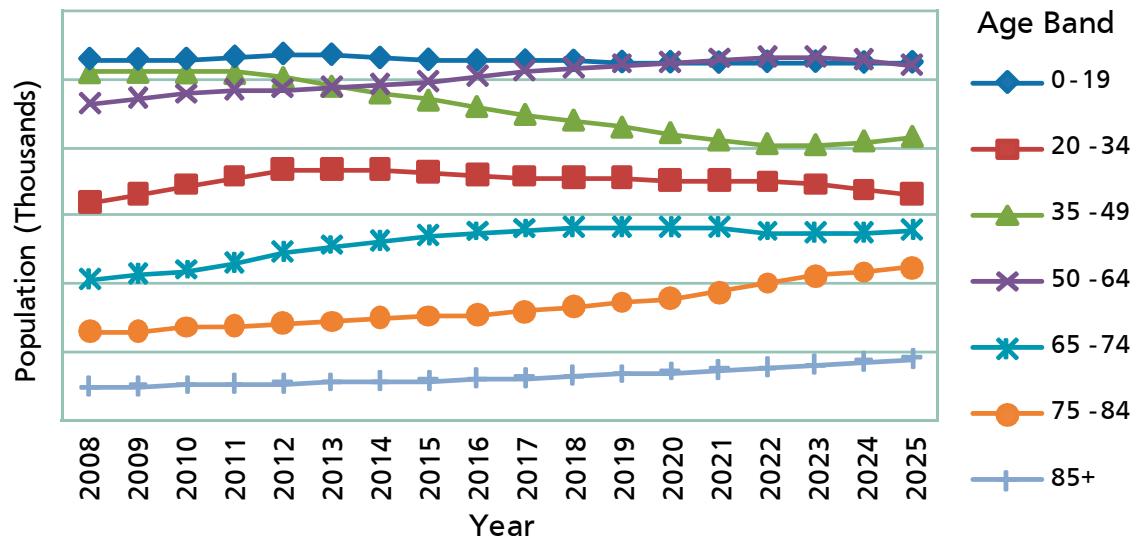
¹ Please note: the word 'Stroud' is used throughout this document to refer to Stroud District.

Figure 1: Stroud population pyramid: showing change in age profile between 2008 and 2025



Source: eJSNA

Figure 2: Stroud District population changes by age band 2008 to 2025



Source: NHS Gloucestershire Public Health Intelligence Unit 2008

Although Gloucestershire has seen an increase in economic migration predominantly from Eastern Europe, Stroud has had considerably less national insurance applications than the rest of the county. With the recent economic downturn it is expected that the number of these applications will be reduced.



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.

There are clear links between deprivation and health, with people living in the most deprived areas experiencing worse outcomes for a number of health-related measures, such as life expectancy, mental health problems and incidence of cancer. Stroud is a relatively affluent district. There are no registered patients living in the most deprived fifth of neighbourhoods nationally.

Figure 3 shows the 'Health Deprivation and Disability' domain of the IMD 2007 for Stroud. This measures rates of poor health, early deaths and disability and shows differences in deprivation between neighbourhoods in Stroud compared to the whole of England. In Stroud district there are two neighbourhoods ranked second most deprived of local neighbourhoods nationally - Cam West and Stonehouse. There are clear links between deprivation and health outcomes for those living in the deprived communities. These relate specifically to life expectancy, poor health, and poor access to services.

¹ See www.communities.gov.uk

Figure 3: IMD 2007 (Stroud District LSOA's) – Health, deprivation and disability domain

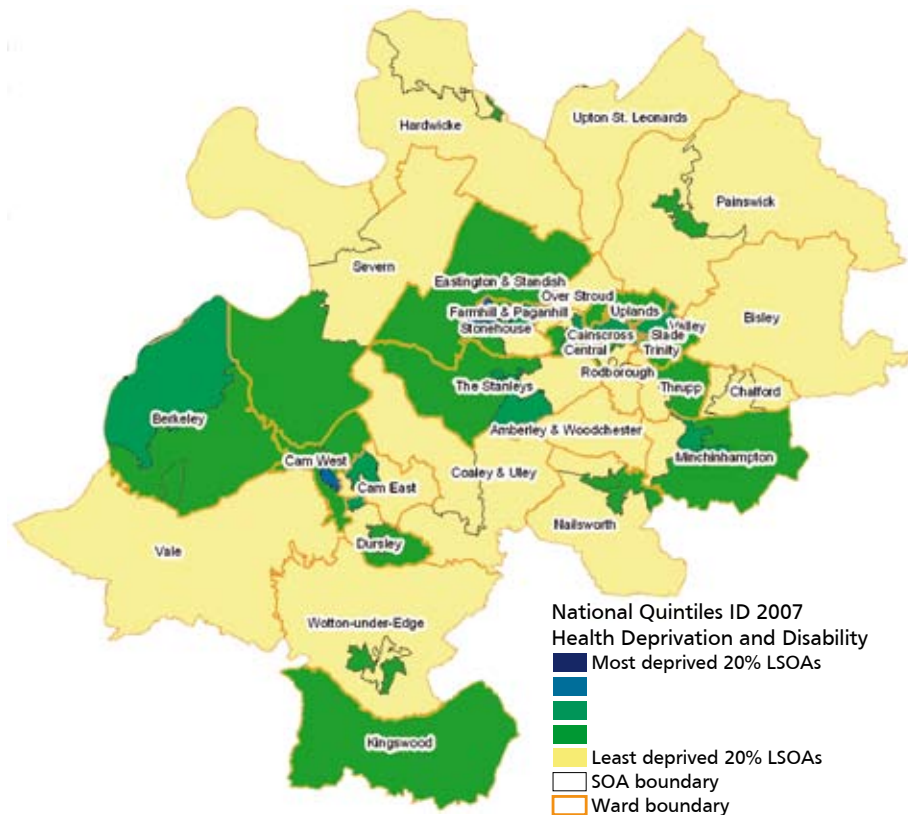
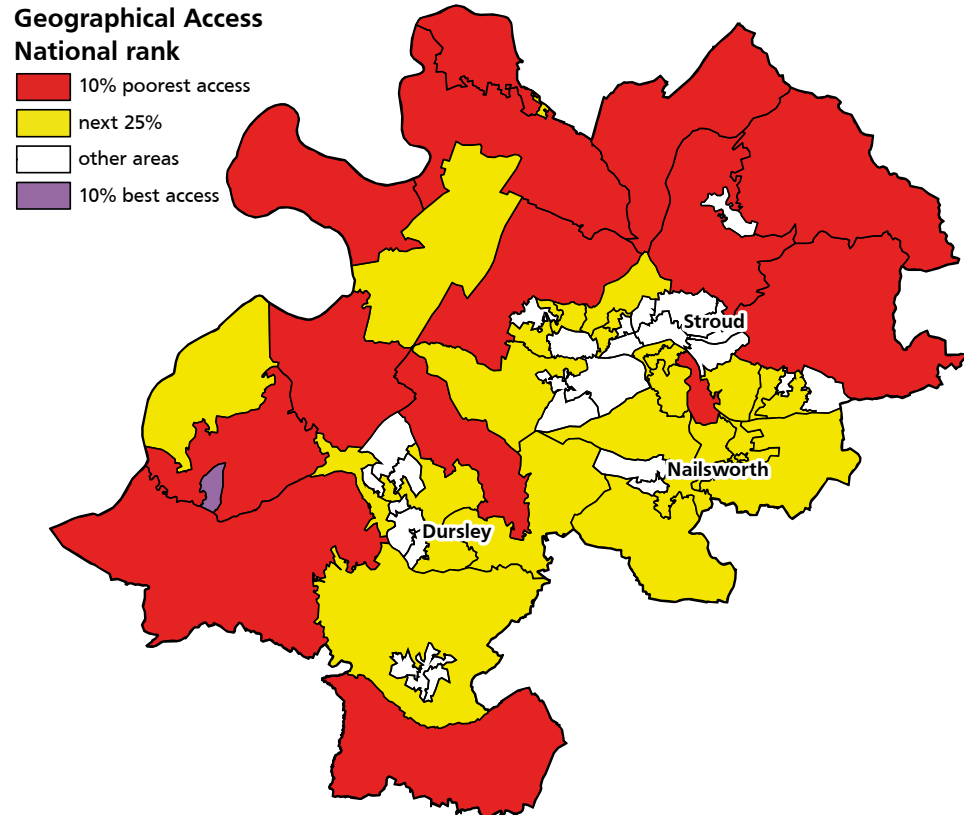


Figure 4 shows the 'geographical barriers' sub domain of the IMD 2007. This is one of two kinds of barriers that make up the 'Barriers to Housing and Services' sub domain of the IMD 2007. The other is 'wider barriers,' which covers housing issues. The geographical barriers sub domain covers geographical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

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



Stroud is predominantly a rural community and access to services is easier around the town centres. Nearly half of Stroud has poor access to services and although this may generally affect the more affluent areas, some of Stroud's deprived areas including Berkeley, Eastington and Standish, also have poor accessibility to services. Vulnerable residents, including young and older people, may need to be supported in order to avoid social exclusion and potential related health hazards.

2 Key issues for Stroud

A number of key issues for Stroud have been identified through the eJSNA in comparison with other districts. (Appendix 1.)

The percentage of children in reception year (aged 4 to 5 years) who are classified as obese is slightly higher in Stroud (10.4%) compared to Gloucestershire (10.0%). The percentage of children who are physically active is lower in Stroud (84.3%) compared to the Gloucestershire average (86.8%). Targeted work with children parents and schools will be necessary to increase the level of physical activities and reduce the number of children classified as obese.

The percentage of physically active adults in Stroud is higher (14.1%) compared to Gloucestershire (12.7%).

The rate of people admitted to hospital with a fractured femur (broken hip) per 1,000 population aged over 75 appears slightly higher in Stroud (13.8) than the rest of the county (12.8).

The rate of people providing unpaid care is higher (99.9 per 1,000 population) than the rest of Gloucestershire (94.7), suggesting a growing problem of care for the elderly.

Key issues for Stroud emerging from the eJSNA are summarised in the box below.

Issues for Stroud

- The increasing older population
- The number of unpaid carers
- The number of older people admitted to hospital after a fall
- The levels of physical activity in children

Source: eJSNA

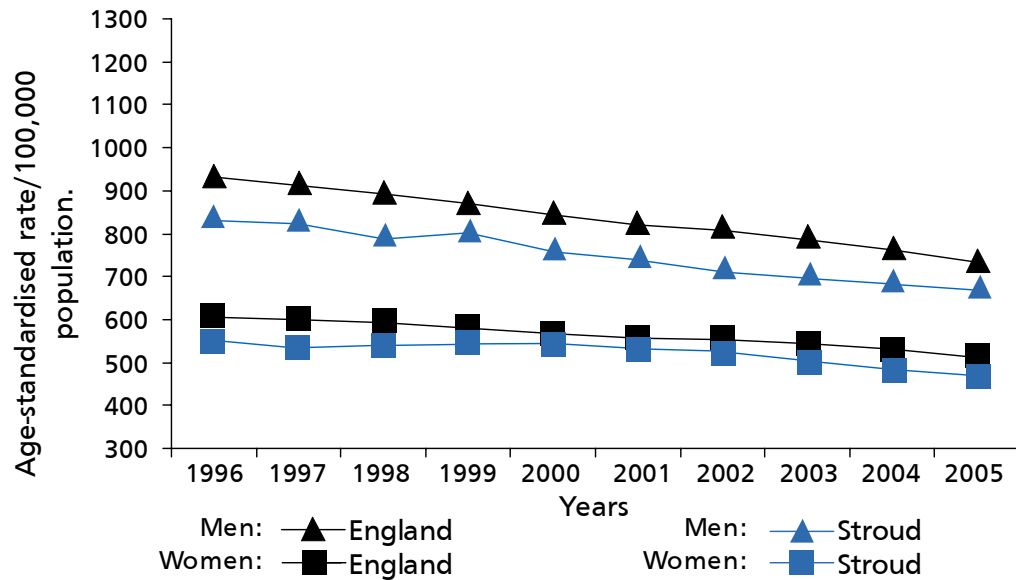


3 Morbidity and mortality

In Stroud District, the all cause mortality and early death rates from heart disease, stroke and cancer have been lower than England as a whole.

The following trend graphs show how changes in health for Stroud district compare with changes for the whole of England. Both the all age, all cause mortality rate (Figure 5) and the rate of early deaths from cancer (in people under 75, Figure 7) in Stroud District are below the England average and they 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.

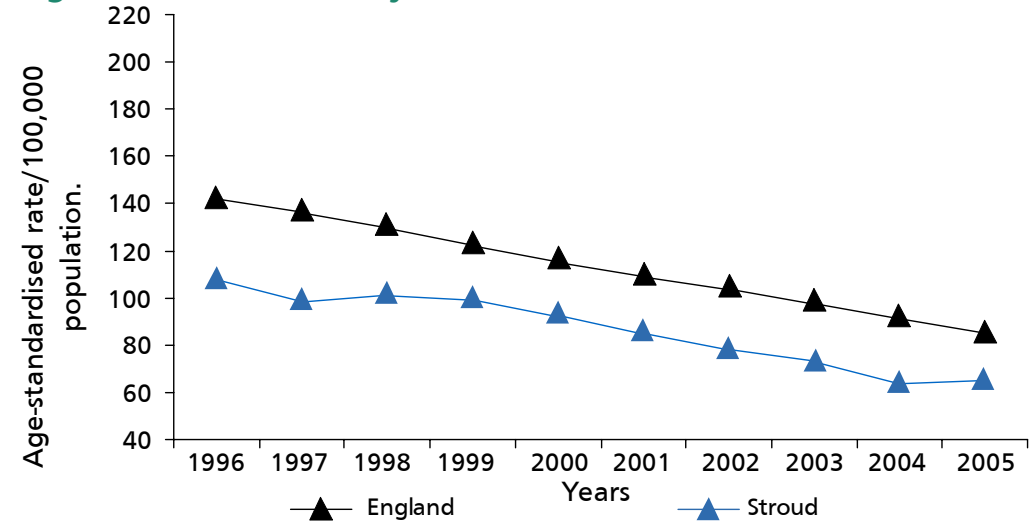
Figure 5: Trend 1: All age, all cause mortality



Source: APHO Profiles 2008



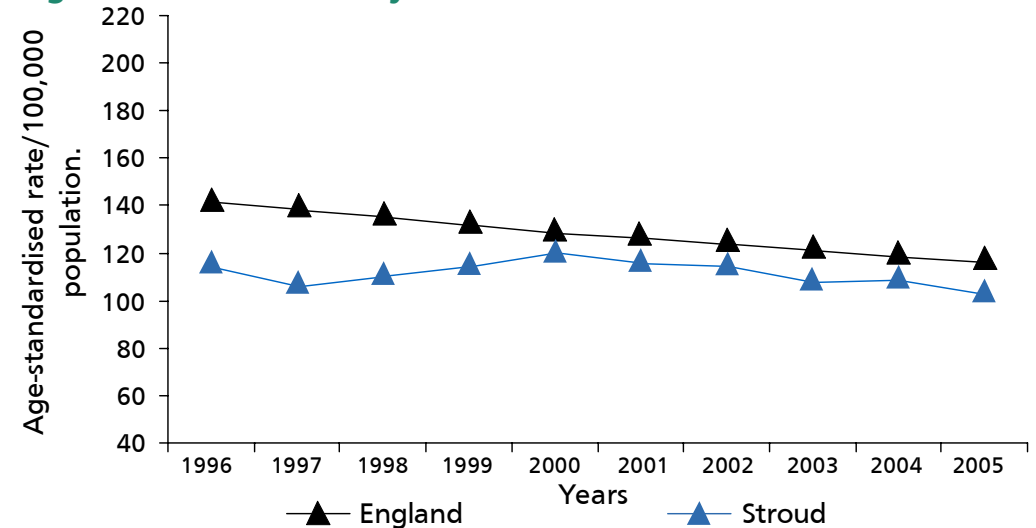
Figure 6: Trend 2 – Early deaths from heart disease and stroke



Source: APHO Profiles 2008

The rates of early death from heart disease and stroke (in people under 75, Figure 6) have also fallen. However, since 2004 the rate has not declined but remains below the England average. As the number of older people rises, initiatives aimed at the prevention and management of heart disease and stroke will be crucial in addressing the potential increase in deaths from these conditions.

Figure 7: Trend 3 – Early deaths from cancer



Source: APHO Profiles 2008

4 Life expectancy: comparing the gap in life expectancy within Stroud District

The Association of Public Health Observatories (APHO) has developed a tool to help primary care trusts 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 Stroud District and to suggest preventive interventions that will impact on the life expectancy gap within Stroud District.

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

The relative gap in life expectancy between Stroud's most deprived areas and Stroud as a whole is greater for males (1.3%) than for females (0.2%). The absolute gap is small. A baby boy born within the most deprived areas in Stroud District can expect to live one year less compared to the average expected life span of boys born in Stroud District as a whole. Similarly a girl born in the most deprived fifth of areas within Stroud District can expect to live around 2.5 months less compared to average expected life span for baby girls in Stroud District as a whole.

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

	Life expectancy at birth (years) Stroud most deprived quintile	Life expectancy at birth (years) Stroud **	Absolute gap (years)	Relative life expectancy gap between MDQ & Stroud LA*
Males	77.2	78.2	1	1.3%
Females	81.8	82	0.2	0.2%

Source LHO: Health Inequality Intervention Tool June 2008

*The relative gap in life expectancy is the difference in life expectancy between Stroud District's most deprived quintile and Stroud District, as a percentage of Life Expectancy for Stroud 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 Stroud District 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 Stroud District 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 Stroud District's most and least deprived areas⁴.

It can be seen that circulatory diseases account for more than a quarter (28.5%) of the gap in female life expectancy whilst respiratory diseases account for a quarter of the gap in male life expectancy in Stroud. Figure 8 also shows us, for example, that eliminating excess deaths from circulatory and respiratory diseases in men would nearly halve the gap in male life expectancy within Stroud District.

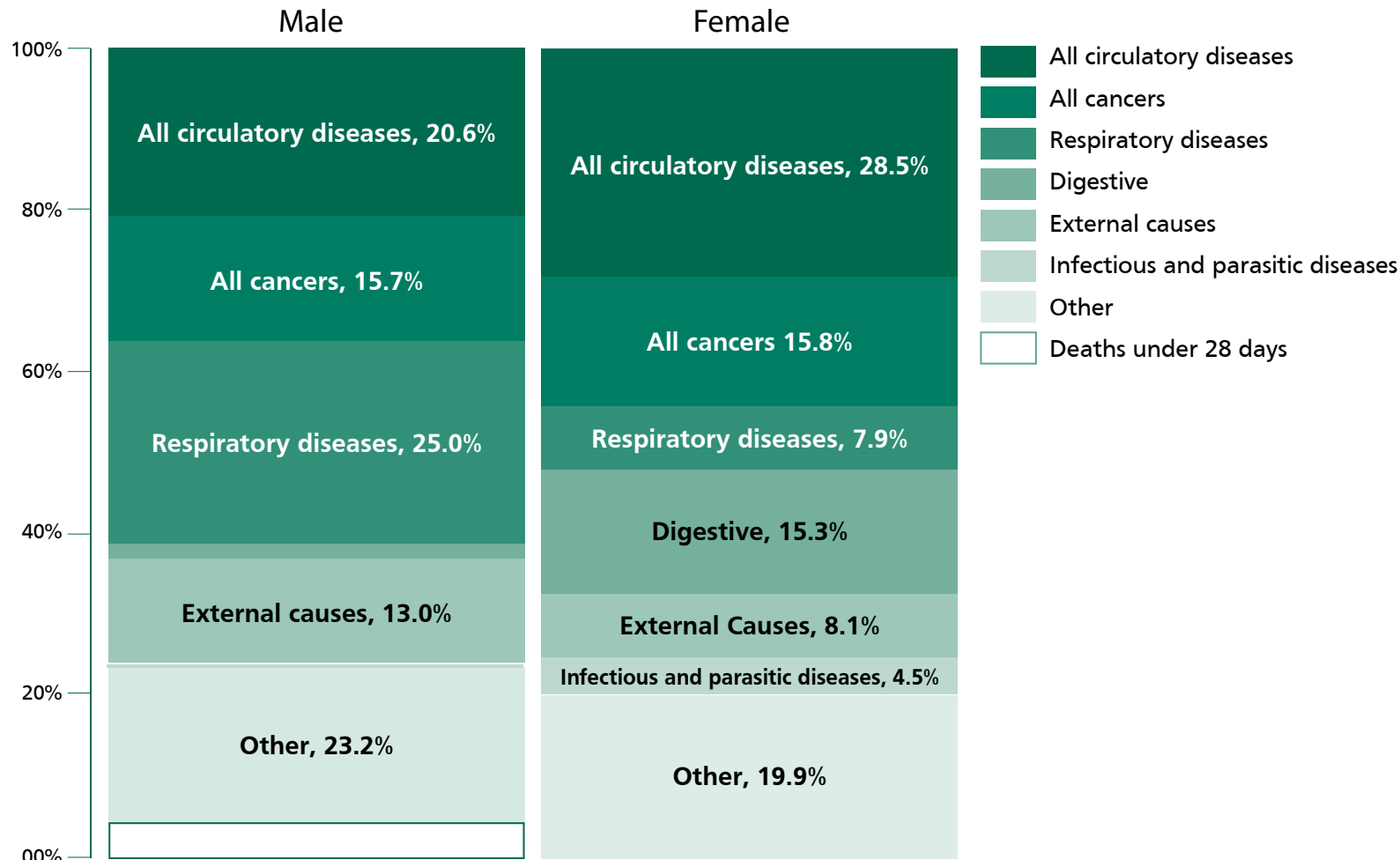


² www.lho.org.uk/HEALTH_INEQUALITIES/Health_Inequalities_Tool.aspx.

³ LHO: Health Inequality Intervention Tool 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.

Figure 8: Breakdown of life expectancy gap between the most deprived quintile (MDQ) of Stroud 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 Stroud 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 Stroud District, if it experienced the same mortality rate as the most affluent fifth of areas for each cause of death separately⁵. It shows us, for example, that if males in the most deprived areas had the same mortality rate from coronary heart disease as males in the most affluent areas they would live nearly half a year 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.

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 Stroud 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 Stroud 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 Stroud 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 Stroud District

Males	Females
Chronic obstructive airways disease	Coronary heart disease
Coronary heart disease	Other digestive diseases
Other cancers	Stroke
Suicide and undetermined injuries	Suicide and undetermined injuries
Other accidents	Chronic obstructive airways disease

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

- smoking cessation
- increasing physical activity levels
- encouraging healthy eating
- reducing alcohol misuse
- raising cancer awareness
- suicide prevention
- accident prevention.

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

- encouraging healthy eating
- smoking cessation
- increasing physical activity levels
- suicide prevention.



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?

Over the next three years the Gloucestershire Local Area Agreement (LAA) has prioritised smoking, obesity, breastfeeding, alcohol misuse, independence for vulnerable people, and reducing falls in over 75s.

The Gloucestershire Health and Community Wellbeing Partnership have identified ten priority areas to focus efforts on over the next ten years:

- Active and healthy ageing
- Reduce obesity
- Reduce alcohol harm
- Reduce smoking prevalence
- Improved sexual health
- Better access to services for all
- Healthier workplaces
- Improved emotional health and wellbeing
- Putting people first – transforming social care

Accessible, healthy and safe housing

NHS Gloucestershire is working closely with the Stroud District Council via the Health and Wellbeing Community Partnership to address these priorities and sustain the achievements to date.

As part of these close working arrangements, NHS Gloucestershire part funds a Health Improvement Facilitator equivalent post within the Council. NHS Gloucestershire is also helping to develop the new Stroud Community Strategy. The new Health and Wellbeing Action Plan, built upon the Gloucestershire Health and Wellbeing Strategy, will be a platform on which to build future actions to address issues identified in this profile.

⁶ *The OTAGO course is a strength and balance exercise programme. Strength and balance programmes have been found to be a specific component common to successful multifactorial intervention programmes to reduce falls – see CG21 Falls: NICE guideline 2004*

Some of the successful initiatives currently underway include the following:

- From April 2009, Stroud District Council, with the support of NHS Gloucestershire, will pilot a children's physical activity GP/teacher referral scheme in Dursley and Cam for 12 months. The scheme will focus on children (ages 7-12) and the family as a whole. Physical activity sessions will run over a period of 12 weeks per family. This will complement the children's gym equipment which is already installed at Dursley Swimming Pools.
- The Play initiative: www.stroud.gov.uk/docs/leisure/sports_play_development.asp) and the ACE (Activity Club for Everyone) are pioneering new clubs putting sport within the reach of people with disabilities and is open for 3-4 sessions per week to those living in the Stroud district.
- 'Dance on Prescription' Scheme will be piloted in April 2009 in Dursley for anyone over the age of 16. This pilot will build upon the existing GP referral scheme which has approximately 500 referrals per year from the local GPs and nurses.
- NHS Gloucestershire has recently trained a number of instructors from across the county on a postural stability (PSI) course which enables the instructor to deliver classes for older people out in the community. During 2009, further courses will be held to train staff on the OTAGO⁶ course. There are currently four physical activity sessions for older people within Stroud district which involve Extend (armchair aerobics) and Tai Chi. These take place at Cashes Green, Randwick and Minchinhampton. The council will be working in partnership with NHS Gloucestershire to deliver falls prevention within these sessions.



- A walking programme targeting primarily older people takes place weekly in Stroud, Stonehouse, Nailsworth, Cainscross and Dursley.
- The Careline service is a Stroud District Council low cost alarm system which has over 1,800 customers within the district. If an older person falls in the home, the Careline is a way of getting help through the telephone system, quickly and efficiently 24 hours a day.
- There are eleven neighbourhood wardens in Stroud district and one of their targets is to meet a vulnerable person every day (including older people). Neighbourhood wardens are trained to provide emergency assistance to older people, raise safety issues with them, as well as to deliver 'EXTEND' type chair bound exercises. They have details of Adult Care Services and can signpost the older people to services such as Village Agents, Careline, Care and Repair and People for You including referrals to alternative exercise schemes for older people.



6 Next steps for 2009-10

The main priorities for 2009- 10 are outlined below and need to be incorporated into the current Sustainable Community Strategy and developed alongside similar initiatives across the county.

We will take appropriate actions through the 'Stroud District Older Persons' Forum following the analysis of the hospital admissions data of hip fractures in the Stroud district.

Further interventions that are focused around physical activities for children and their families need to be made available across the district.

We will explore ways to support carers in the district in accordance with County initiatives, led by the Health and Community Wellbeing Partnership.

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:
Nevila Kallfa, Health improvement
Principal – Clinical Effectiveness,
NHS Gloucestershire
nevila.kallfa@glos.nhs.uk

Appendix 1: Key statistics for Stroud

Domain	Indicator	Number	Stroud Rate	Gloucestershire Rate
Social demography	Resident population, 2008 (local population projection 2008) % of total Gloucestershire population	114,203	19.1	
	Geographical area (square km) % of total area of Gloucestershire	476	17.6	
	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)	2,132	47.8	51.0
	Lone Pensioner households (self-reported at 2001 Census) (rate per 1,000 population)	6,546	146.7	149.3
	Overcrowded households (calculated from 2001 Census returns) (rate per 1,000 population)	1,486	33.3	45.5
	Black and minority ethnic groups 2001 Census (% district total, county overall %)	1,435	1.3	2.8
Lifestyle	Estimate of adults who smoke 2003-05 (%)	n/a	21.0	24.6
	Deaths from smoking 2004-06 (per 100,000 population 35+)	187	188.7	191.8
	Estimated Healthy eating adults, 2003-05 (%)	n/a	25.6	19.4
	Estimate of obese adults, 2003-2005 (%)	n/a	22.7	24.3
	Physically active adults aged 16+, 2005-06 (%)	n/a	14.1	12.7
	Hospital stays related to alcohol, 2006-07 (directly age standardised rate per 100,000)	194	172.2	200.8
	Road injuries and deaths 2004-06 (crude rate per 100,000 population)	41	37.3	47.3
Children and young people	Obese children in reception year, 2006-07 (%)	103	10.4	10.0
	Physically active children aged 5-16, 2006-07 (%)	11,853	84.3	86.8
	Teenage pregnancy, 2004-06 (under 18 conception rate/1000 females)	51	23.6	30.0
Independent living	Independent living: Persons receiving CACD Home Care during 2006-07 (rate per 1,000 population)	1,119	10.1	9.3
	People providing unpaid care (self-reported at 2001 Census) (rate per 1,000 population)	11,490	99.9	94.7
Older people	Falls: Over 75s admitted to hospital with a fractured femur 2005-07 (rate per 1,000 aged over 75)	140	13.8	12.8
Morbidity and mortality	People with limiting Long-Term Illness (self-reported 2001 Census) (rate per 1,000 population)	17,092	148.6	155.1
	Life expectancy at birth 2005-07 - male		78.3	78.7
	Life expectancy at birth 2005-07- female		82.7	82.7
	All age all cause mortality 2005-07 (age standardised rate per 100,000 population)		552.6	542.5
	All cause mortality in under 75s 2005-07 (age standardised rate per 100,000 population)		251.4	259.5
	Mortality rate for circulatory diseases in under 75s 2005-07 (age standardised rate per 100,000 population)		63.1	62.2
	Mortality rate for cancer in under 75s 2005-07 (age standardised rate per 100,000 population)		103.4	104.3
Mental Health	Outpatient first attendances: adult mental health: 2006-07 (rate per 1,000 population)	219	1.9	2.3
	Incapacity benefits for mental illness, 2006 (rate per 1,000 working population)	1,350	20.6	21.8

