

NHS Gloucestershire: 2026/27 Integrated Needs Assessment

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Our Integrated Needs Assessment

Executive summary

This Integrated Needs Assessment sets out a detailed understanding of the Gloucestershire population, its current health and wellbeing needs, and projected future trends. This report responds to national guidance that sets out the elements and sources required. It aims to inform strategic commissioning decisions across the Gloucestershire Integrated Care System (ICS) for 2026/27.

Gloucestershire is a broadly healthy county, performing well on many health indicators including higher life expectancy and lower preventable mortality than the England average. However, these strengths mask significant inequalities, particularly in parts of Gloucester, Cheltenham, and rural areas where deprivation, poorer housing, limited access to services, and worse health outcomes persist.

Gloucestershire's population is also ageing rapidly, with the proportion of residents aged 65+ and 85+ projected to grow substantially. This shift will increase demand for health and social care, particularly urgent care and community support. This will be driven by a higher proportion of people with chronic conditions such as coronary heart disease, type 2 diabetes and cancer – many of which present at the same time for the same individuals (multimorbidity) and a loss of resilience (frailty).

Preventable ill health – driven by risk factors such as cardiovascular disease, smoking, obesity, and physical inactivity – continues to shape outcomes, with variation between communities.

The report highlights major opportunities for commissioners to target resources towards prevention, early intervention, improved access, and integrated locality-based models of care.

Purpose and scope

The purpose of the Integrated Needs Assessment is to inform strategic commissioning decisions within the Gloucestershire Integrated Care System (ICS) through setting out key areas of challenge and opportunity through analysis of the population's health and wellbeing outcomes and needs.

The scope of this assessment includes a broad analysis of Gloucestershire residents' demographics, health outcomes, and access to health and care services. It does not cover all health conditions and services. Instead, key areas of need, population trends, and challenges to Gloucestershire health and care services have been outlined to focus attention on leading areas of opportunity for future strategic commissioning.

Methodology

The information in this report is primarily drawn from quantitative analysis of local data, with additional insights from qualitative service user feedback. Information has been sourced from existing reports, data from Gloucestershire health and care services, service user feedback, and population health management data, among others. The Gloucestershire Integrated Care Board (ICB) and Gloucestershire County Council (GCC) have collaborated on the development of this needs assessment.

About Our Population

A growing and ageing population

The population in Gloucestershire has been growing. Over the last 10 years the county's population has risen by 9.5%, outpacing the national average of 7.8%, but growth across districts hasn't been even. Cheltenham has seen the lowest growth in the county at 4.0%, while Tewkesbury has seen the greatest growth of 20.1% during this time, creating an increased demand for services in this part of the county.[1]

Looking ahead to 2047, Gloucestershire's population is projected to grow by 113,929 people: an increase of 17.6%, substantially above the 12.7% forecast for England.

Trend based projections suggest natural change will lead to more deaths than births (decreasing the population by 46,383), the overall growth is heavily impacted by people from other parts of the country moving into the county. This inward net migration is expected to increase the population by almost 150,000 people.

Gloucestershire's population has also been ageing, and faster than the national average. People aged 65 years and over made up 22.1% of the population in 2024, well above the national average of 18.7%. In rural areas like the Cotswolds and Forest of Dean, that figure climbs above 25%. As a result, the county has proportionately fewer children and working-age adults than the national average.[2]

The ageing of Gloucestershire's population is expected to continue. The highest areas of population growth among those living in Gloucestershire will be among people over the age of 65, with a projected increase of 43% between 2022 and 2047 (111% growth for people over 85). By contrast, the population of children and young people (ages 0-15) is projected to show a decline of ~5% over the same [3].[4] This will mean that the Older Age Dependency ratio, currently at 370 people in retirement age for every 1,000 people of working age, will increase in every area of the county – the highest in the Cotswolds (496 per 1,000) and Forest of Dean (302 per 1,000).

These changes carry implications for both service demand and the capacity of the working age population to support such demand. As people grow older and frailer, they will need more support from health, social care, and safeguarding services.

[1] Mid 2014-Mid 2024 Population Estimates, ON
[2] *Ibid*.

[4] 2022 based Subnational Population Projections (migrant category), ONS

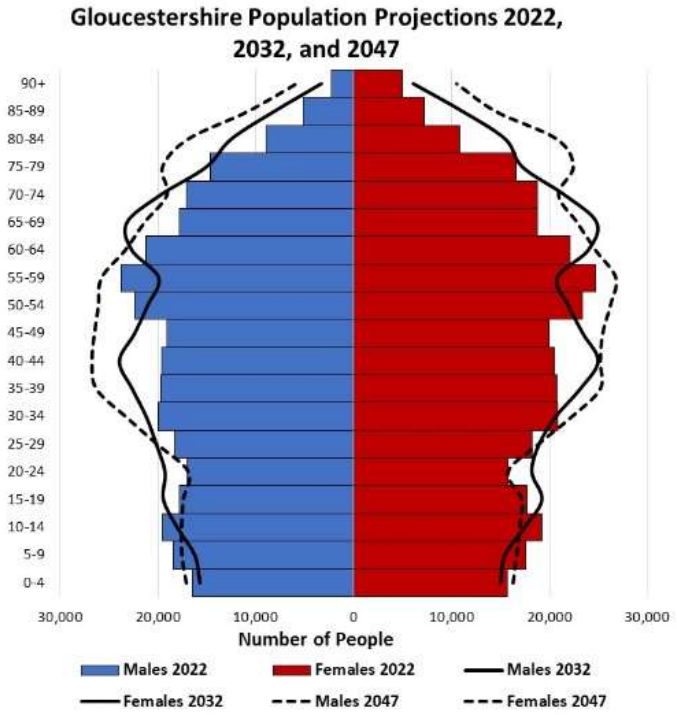


Figure 1: Gloucestershire's Population Projections 2022, 2032 and 2047[5]

The composition of households in Gloucestershire is also expected to change. The proportion of one person households is expected to increase from 31% of total households (2022) to 36% (2047). This development will likely add to existing challenges such as social isolation and demand on care services.

Strong but variable life expectancy

Overall, health outcomes in Gloucestershire are better than the national (England) average. During 2021-2023, deaths from causes considered preventable were significantly below the national average[6]. *Figure 2* shows that life expectancy at birth and at aged 65 is better in Gloucestershire compared to England overall[7]. However, there are differences across the county; for instance, life expectancy in Gloucester is significantly below the national average.

Substantial inequalities exist between different areas of the county. Life expectancy for males is lowest in the Kinsgholm and Wotton area with a life expectancy at birth of 72.1 years, compared to 83.9 years in Kemble and South Cerney. Similar inequalities persist within female life expectancy; Kinsgholm and Wotton also has the lowest female life expectancy at birth at 77.3 years, compared to 88.5 years in Abbeymead and Abbeydale.[8]

[5] *Ibid*.
[6] PHOF, OHID
[7] Life expectancy for local areas between 2001 to 2003 and 2021 to 2023, ONS
[8] Life expectancy at MSOA level, 2019-2023, Local Health, OHID

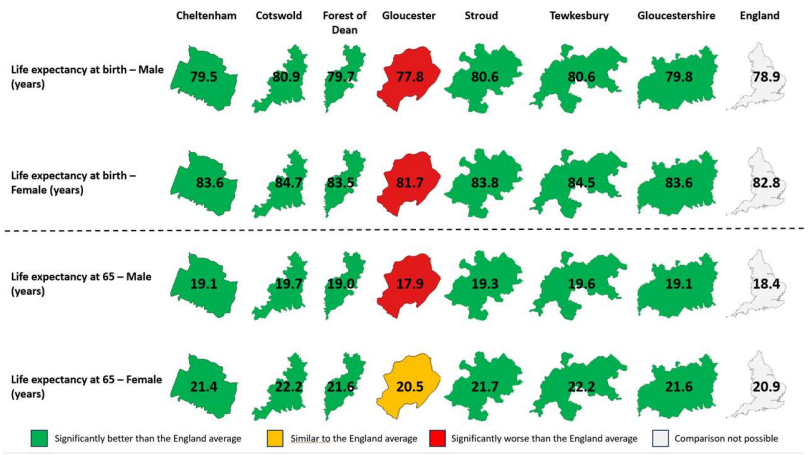


Figure 2: Life expectancy in Gloucestershire and districts, 2021-2023[9]

Positively, Gloucestershire residents experience poor health later than the national average. In Gloucestershire, healthy life expectancy at birth for males is 63.7 years and 63.6 years for females (2021-2023), compared to the England averages of 61.5 and 61.9 years respectively (though these differences are not statistically significant). [10] It is important to highlight regardless that males and females in Gloucestershire are likely to live a significant proportion of their life in poor health.

Avoidable yet persistent health inequalities

Health inequalities are unfair and avoidable differences in health between different groups of people within society. Characteristics of people or places most often associated with differences in health outcomes include people from ethnic minorities, those with disabilities, people facing socio-economic disadvantages, people with mental ill health, and those who are geographically or socially isolated, among others. [11]

Ethnicity

Gloucestershire is characterised by a comparatively small proportion of people who identify as ethnic minorities compared to the national average. In 2021, 87.7% (600,314 people) of Gloucestershire's population identified as "White British", compared to the national average of 81.0%.[12] Notwithstanding, Gloucestershire's population of people from Black and Asian backgrounds increased by 63.8% between 2011 and 2021, from 4.6% to 6.9% of the total population.[13] When including white minorities, the proportion of people in Gloucestershire from an ethnic minority rose to 12.3%.[14]

Parts of the county are more diverse than others. Barton and Tredworth in Gloucester is the most ethnically diverse area of the county (see Figure 4), with more than 30% of the population classed as ethnic minorities. Other areas with a high proportion of people from ethnic minorities include parts of Innsworth in Tewkesbury, Kingsholm and Wotton, Westgate, Moreland and Coney Hill in Gloucester and Lansdown in Cheltenham.

[9] *Ibid.*
[10] Health state life expectancies in England, Northern Ireland and Wales, ONS
[11] Health inequalities: place-based approaches to reduce inequalities - GOV.UK
[12] 2021 Census, ONS
[13] 2011 Census and 2021 Census, ONS
[14] Inform Gloucestershire

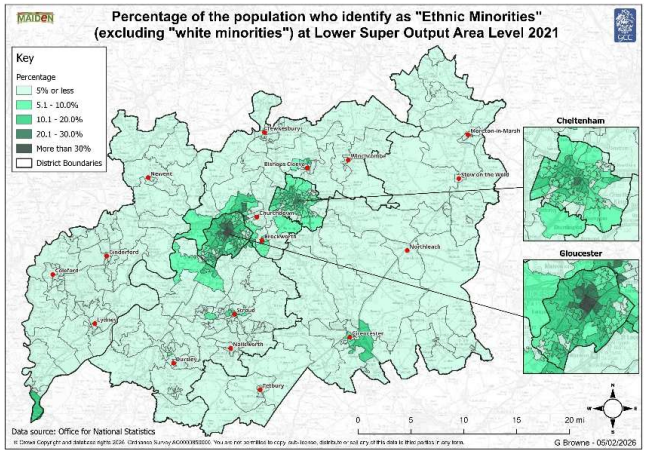


Figure 2: Percentage of the population who identify as "Ethnic Minorities (excluding white minorities" at Lower Super Output Area, 2021[15]

People from Black and minority ethnic groups in Britain have been shown to experience discrimination and inequality in healthcare outcomes, as well as in education, employment, housing, pay and living standards, and the criminal justice system.[16] In addition, people from Asian or Asian British ethnicities are more likely to have dominant psychiatric / behavioural diagnoses compared to other groups. Data from the 2021 Census indicates similar patterns in Gloucestershire whereby:

- Ethnic minorities aged 65 and over had a significantly higher proportion of respondents stating they were in bad or very bad health than the white population (12.8% vs 9,8%).
- Ethnic minorities aged 16-64 had a significantly higher unemployment rate than the white population (4.9% vs 3.2%).
- The rate of people living in overcrowded households was significantly higher amongst ethnic minorities than the white population. (10.8% vs 3.4%)[17]

Deprivation

Multiple deprivation has well documented implications for health and social outcomes. Gloucestershire is comparatively well-off as a county, sitting in the least deprived 20% of authorities across England on the national Index of Multiple Deprivation 2025 (IMD 2025).[18] However, there are pockets of deprivation within the county. Gloucester and the Forest of Dean are the most deprived districts according to the Index[19]

In terms of IMD 2025 multiple deprivation, 29 out of the 393 small areas in Gloucestershire are amongst the 20% most deprived in England (described in the NHS as the CORE20 areas) (see Figure 5). A small minority (7.3%) of Gloucestershire residents (48,790 people) live in these.[20] Most are in urban parts of Gloucester and Cheltenham, with a few exceptions. Additionally, 3.1% of Gloucestershire residents

[15] 2021 Census ONS
[16] Equality and Human Rights Commission (2016), Healing a divided Britain: the need for a comprehensive race equality strategy Healing a divided Britain: the need for a comprehensive race equality strategy | EHRC (equalityhumanrights.com)
[17] 2021 Census, ONS
[18] Indices of Deprivation 2025, MHCLG
[19] *Ibid*.
[20] *Indices of Deprivation 2025, MHCLG and Mid 2024 Population Estimates, ONS*

(20,960 people) live in areas that are among the 10% most deprived in England.[21]

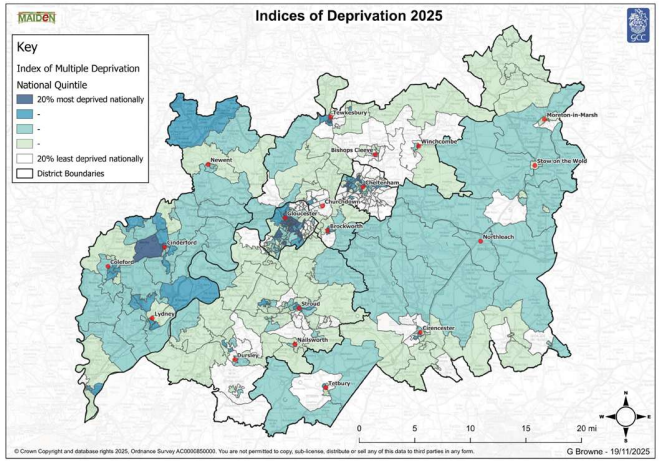


Figure 53: Index of Multiple Deprivation 2025, National Quintiles[22]

Major methodological changes since the 2019 Indices of Deprivation make it difficult to understand changes in deprivation over time. Nevertheless, deprivation in Gloucestershire appears to remain persistent, with many areas amongst the most deprived 10% nationally, reflected both in the 2025 Indices and in previous versions.[23]

Living in areas of deprivation can have a significant impact on residents' life chances. Analysis in 2019 showed that, compared to residents living in areas among the 20% least deprived nationally, those living in areas amongst the 20% most deprived are:

- three times as likely to have a still birth[24]
- almost twice as likely to be obese in year six[25]
- almost five times as likely to be claiming unemployment benefits.[26]

As people get older, our population health analysis (see Figure 6) shows that people living in more deprived areas of the county will fall into poorer health faster than those people living in more affluent areas (an average score gap of 0.35, measured by differences between the population need groups). This life course health gap is most prominent at retirement age (65-69 with a gap of 0.82) but starts increasing from the ages of 40-44.

[21] *Ibid*.
[22] Indices of Deprivation 2025, MHCLG
[23] Indices of Deprivation 2019, MHCLG and Indices of Deprivation 2025, MHCLG
[24] ONS births, 2017-2021
[25] NCMP 5 year Pooled Analysis (2016/17-2021/22, excluding 2020/21)
[26] Claimant Count, ONS

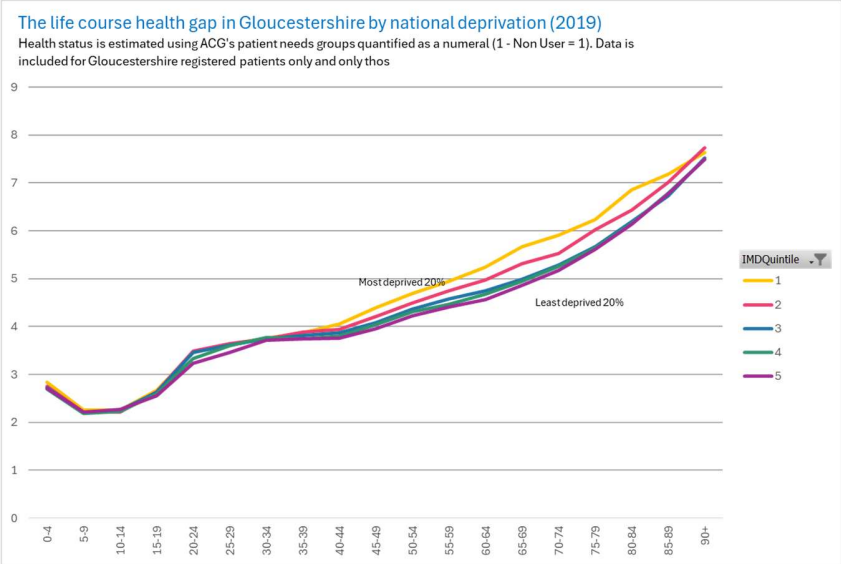


Figure 6: Life course health gap in Gloucestershire, 2019

In addition, 2021-2023 data showed that males born in the most deprived deciles of Gloucestershire could expect to live 8 years and 2 months less than those born in the most affluent deciles, or 6 years and 7 months less for females.[27]

Nearly 20% of Gloucestershire residents live within the most deprived 20% nationally for their living environment and barriers to housing and services (19.4% and 18.5%, respectively).[28]

The Gloucestershire population experiences comparatively lower levels of health deprivation and disability, with only 6.8% living in areas amongst the 20% most deprived nationally (45,518 people).[29] There are, however, areas of the county with high levels of health deprivation and disability; seven LSOAs in Gloucester all sit in the top 5% nationally in terms of levels of health deprivation and disability.

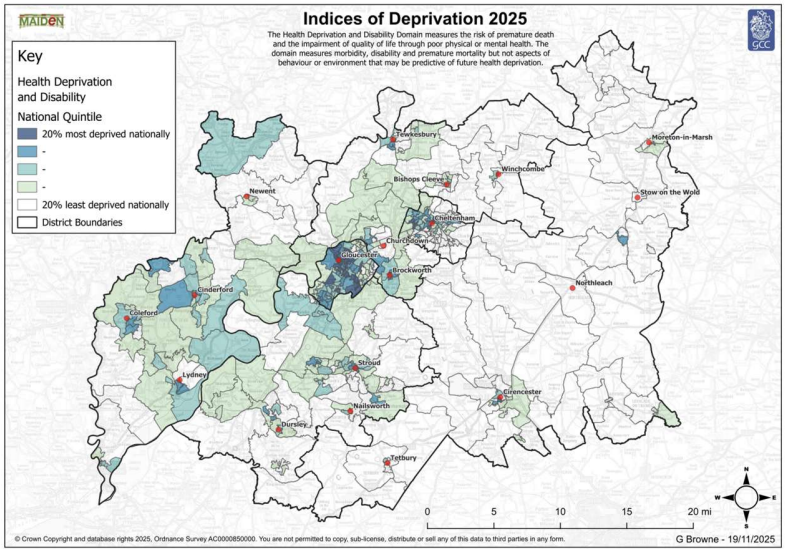


Figure 74: Health Deprivation and Disability, 2025, National Quintiles[30]

Rurality

Gloucestershire is predominantly rural: 87.5% of the total land area was classified as rural in 2021. [31] However, the majority of the population (70.8%) lives in urban areas of the county.[32]

[27] PHOF, OHID
[28] *Ibid*.
[29] *Ibid*.
[30] *Ibid*.

[31] Rural Urban Classification, 2021, ONS and Standard Area Measurements, ONS
[32] Rural Urban Classification, 2021, ONS and Mid 2022 Population Estimates, ONS

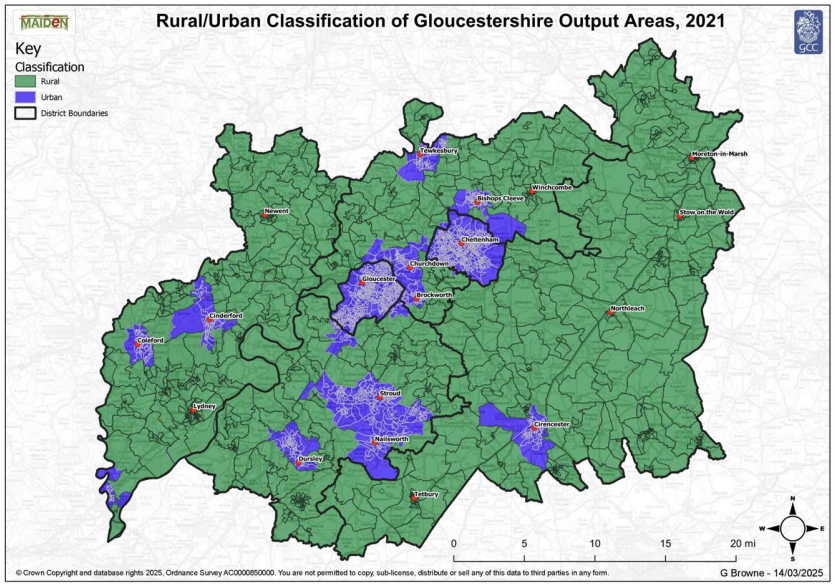


Figure 85: Rural/Urban Classification of Gloucestershire Output Areas, 2021[33]

Generally, people living in rural areas have poorer access to key services than people in urban areas. This is a particular problem for those who do not have a car. This lack of accessibility can exacerbate the impact of deprivation in these areas, making it harder for people to access opportunities and support.

A 2024 review of the accessibility of services when using public transport showed persistent challenges in accessing health services, with marked differences for those living in the rural districts of Cotswold and Forest of Dean. The review found that:

- 15.4% of the Gloucestershire population could not access A&E or Minor Injury Unit within 45 minutes - increasing to 35.5% of Cotswold residents and 44.8% of residents in Forest of Dean.
- 5.4% of the Gloucestershire population could not access a pharmacy within 45 minutes, increasing to 16.3% of Cotswold residents.
- 5.0% of the Gloucestershire population could not access a GP within 45 minutes, compared to 16.7% of Cotswold residents.[34]



[33] Rural Urban Classification, 2021,

[34] JTAM 2024, Data and Analysis Team, Gloucestershire County Council.

Health Outcomes for Our Population

Starting Well

- Children's health is critical because it forms the foundation for lifelong physical and mental well-being, influencing educational attainment, employment prospects, and future health outcomes.

Declining proportion of children and young people

In 2024, 17.5% of Gloucestershire's population was aged 0-15, lower than the national average of 18.4%. [35] Furthermore, population projections suggest a decline in the number of children and young people (aged 0-15) by -4.5% (5,410 people) over the 25-year period 2022-2047.

However, this decline is lower than the -7.3% projected at a national level. Moreover, considerable variation is expected across the county. Stroud and Tewkesbury are expected to see increases of 3.6% and 8.4% respectively in the number of children and young people between 2022-2047. All other districts are expected to see a decline in this age group during this period, with the greatest at 16.3% expected in Cheltenham. [36] These differences will create uneven demand for services across the county.

The number of births is a dominant driver of the child population. In 2024 there were 5,826 births in the county – among the lowest yearly figures over the last 10 years. At county and national level, the number of births has been on a downward trend, particularly since 2013.

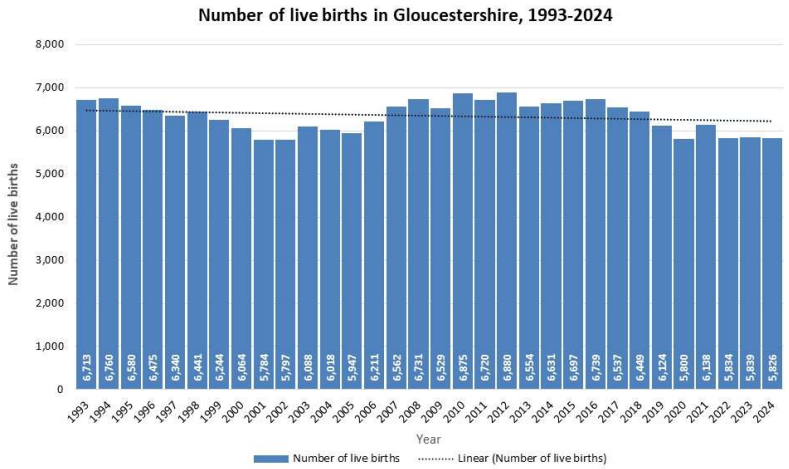


Figure 96: Number of live births in Gloucestershire, 1993-2024[37]

However, population projections suggest the number of live births in Gloucestershire will gradually increase over the coming years, returning to 2018 levels by 2047.[38]

Foundations for future health

Childhood poverty

The Marmot Review (2010) presents clear evidence that childhood poverty is linked to childhood physical and mental health and educational outcomes, which are in turn linked to poor health and social outcomes in adulthood and premature mortality.

[35] Mid 2014-Mid 2024 Population Estimates, ONS
[36] 2022 based Subnational Population Projections (migrant category), ONS
[37] Live Births, ONS
[38] 2022 based Subnational Population Projections (migrant category), ONS

In 2023/24, an estimated 17.3% of children in Gloucestershire under 16 lived in relative low-income families.[39] This was below the national average of 22.1% but still equates to 20,000 children and young people.[40]

The proportion of children living in relative low-income families varies between and within districts (see Figure 10). Gloucester has the highest proportion (22.9%) of children living in relative low-income families in the county, significantly higher than the national average. By contrast, the proportion is significantly lower in Cheltenham, Cotswold, Stroud, and Tewkesbury.

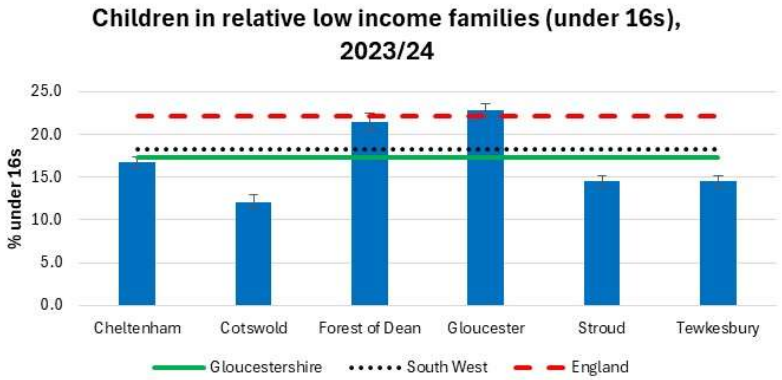


Figure 107: Children living in relative low income families (under 16s), 2023/24[41]

[39] The proportion of children under 16 living in households with incomes below 60% of the median household income in the same year before housing costs.
[40] DWP statxplore and Mid Year Population estimates, ONS
[41] *Ibid*.
[42] Pupil Wellbeing Survey, 2024, Gloucestershire County Council
[43] https://mft.nhs.uk/rmch/services/camhs/youngpeople/adverse-childhood-experiences-aces-andattachment/

Reducing the number of children who experience poverty would improve these adult health outcomes and increase healthy life expectancy in Gloucestershire.

Adverse Childhood Experiences (ACEs) and their impact

ACEs are potentially traumatic events that occur during childhood, such as abuse, neglect, or witnessing domestic violence. They are more common among children living in deprivation.[42]

In 2024, 11.4% of pupils aged 14-17 reported they had experienced four or more ACEs in the Gloucestershire Pupil Wellbeing Survey.

Exposure to ACEs in childhood is linked to an increase in the risk of health problems in adulthood, including cancer, heart disease, mental health difficulties, alcoholism, and suicide attempts in adulthood,[43, 44] as well as an increased risk of violence, and/or becoming a victim of violence[45]

Awareness of the prevalence of ACEs and their impact, and efforts towards prevention through safeguarding, are therefore an area for consideration in commissioning for population health.[46]

Special Educational Needs

Data shows that there are a significant number of children in Gloucestershire receiving support for special educational needs

[44] Associations Between Adverse Childhood Experiences, High-Risk Behaviors, and Morbidity in Adulthood - ScienceDirect
Trauma - CAMHS

[46] Trauma - CAMHS

(SEN). Children identified as having SEN can receive two types of support: school-led SEN support, and/or an Education Health & Care Plan (EHCP). In January 2025, there were 15,594 children and young people receiving school-led SEN support in Gloucestershire schools, equating to 15.3% of pupils. In addition, 6,414 (3.6%) of residents aged 0-24 years had an EHCP[47].

These numbers have increased every year for the past five years. For example, those with an EHCP increased by more than 48% between 2021 and 2025, rising from 4,332 to 6,414.[48] This increase in demand presents challenges for the education sector now and in the future, when this cohort may need additional support to enter the workforce.

In 2023/24, 68.2% of children in Gloucestershire (compared with 67.7% nationally) reached a good level of development at the end of Early Year Foundation Stage; 31.8% did not.

Children eligible for free school meals, those with SEN and disabilities, and children from some minority ethnic groups (compared to 'white British' groups) are more likely to havepoor outcomes in reception and at Key Stage 4.[49]

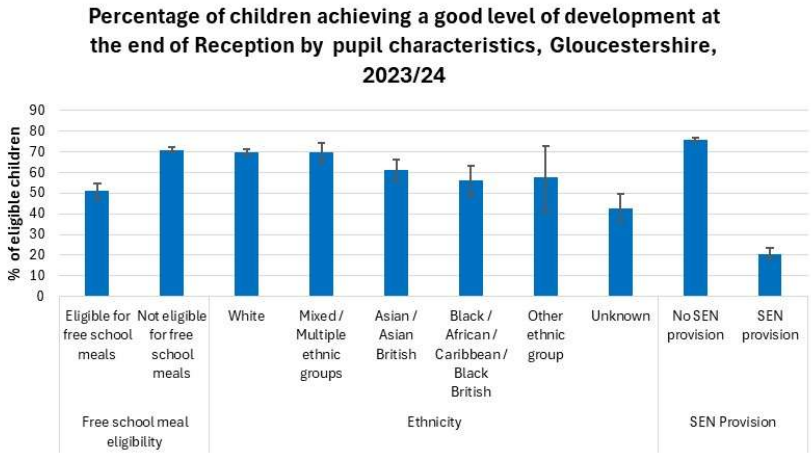


Figure 118: Percentage of children achieving a good level of development at the end of Reception by pupil characteristics, Gloucestershire, 2023/24[50]

Achieving educational qualifications can lead to better job opportunities, better quality work, and a higher income. These determinants are also linked to improved health behaviours (those actions and habits that influence our health).[51]

Health behaviours

Smoking

Smoking in pregnancy has well known detrimental effects for the growth and development of the baby and health of the mother. On average, smokers have more complications during pregnancy and labour, including bleeding during pregnancy, placental abruption, and pre-term rupture of membranes. In 2024/25, an estimated 388

[47] SEND JSNA, Gloucestershire County Council
[48] DAIT, GCC
[49] Pupil Wellbeing Survey, 2024
[50] Explore Education Statistics, DfE
[51] Why Education Matters for Health, the Health Foundation

women in Gloucestershire were smoking at the time of the delivery, which equated to 6.9% of deliveries (significantly higher than the national average of 6.1%). However, this figure has fallen significantly since 2022/23 and the gap between the county and national average is narrowing.[52]

The Tobacco Control Plan [53] highlights the importance of reducing the number of young people taking up smoking, as it is "an addiction largely taken up in childhood". In 2024, 9 in 10 pupils in Gloucestershire schools said they had never smoked and 95.9% said they had never smoked/tried once or twice. This was significantly higher than in 2012 when only 89.0% of pupils said they had never smoked/tried once or twice.

The current proportion of comparable-age pupils who do not smoke (never smoked/tried once or twice) in Gloucestershire is lower than the latest available national figure (95.9% in Gloucestershire[54] versus 96.9% in England)[55] , although it has improved since the last survey.

In 2024 84.3% of pupils reported they had never vaped (used e-cigarettes), this was a slight increase on the proportion from 2022 (82.3%). 92.4% of pupils reported they had never vaped or had only tried it once or twice. This figure was in line with 2022 (91.2%)[56].

Childhood obesity

There is concern about the rise of childhood obesity and the implications of obesity persisting into adulthood. The risk of obesity in adulthood and obesity-related ill health increase as children get older. Data for 2023/24 show that the prevalence of obesity among Reception children in Gloucestershire (9.3% or 570 children) is not significantly different to the national average, while the obesity rate among Year 6 children in Gloucestershire (19.9% or 1,290 children) is significantly lower than the England average. [57] However, childhood obesity is not experienced equally across Gloucestershire; children living in more deprived or urban areas are more likely to be affected, with Figure 11 showing more than double the number of year six children are living with obesity in the most deprived compared to the least deprived area (in the most deprived areas around 3 in 10 children are obese, compared to 1 in 10 in the least deprived areas) . National and local data also show that boys and children from Black ethnic backgrounds have significantly higher rates of obesity. These patterns highlight the need to address the wider social and environmental factors that influence children's health.

[52] Child and Maternal Health Profile, OHID
[53] Smoke-free generation: tobacco control plan for England - GOV.UK
[54] Pupil Wellbeing Survey, GCC
[55] Smoking, Drinking and Drug Use among Young People in England, 2021 - NHS England Digital
[56] Pupil Wellbeing Survey, GCC
[57] Child and Maternal Health Profile, OHID

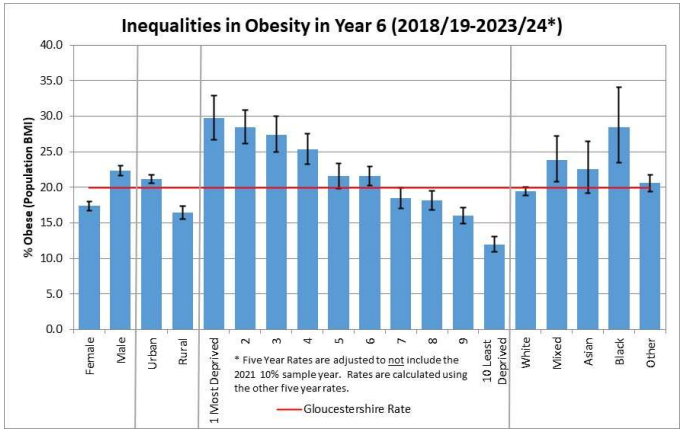


Figure 129: Inequalities in Obesity in Year 6 (2018/19-2023/24)[58]

Alcohol consumption among children and young people

Drinking alcohol at any age can lead to health problems but this is especially true in children and young people[59]. Hospital admission episodes for alcohol-specific conditions in under 18s (period 2021/22 - 2023/24) were significantly higher than the national average; 31.8 admissions per 100,000 population in Gloucestershire compared to 22.6 nationally. Cheltenham seems to be driving Gloucestershire's high rate with 64.1 hospital admission episodes per 100,000 population (see Figure 13), significantly higher than the county and national average.

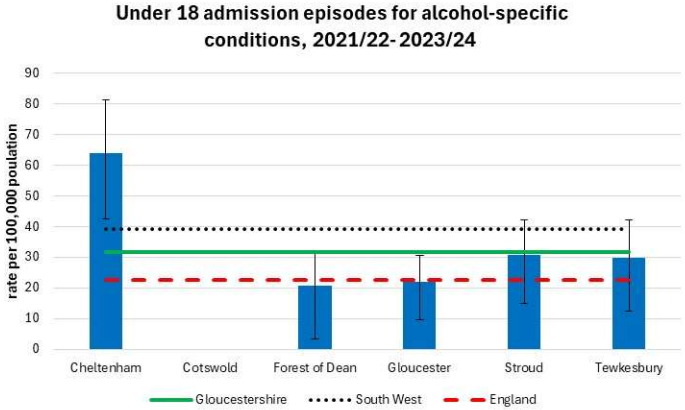


Figure 1310: Under 18 admission episodes for alcohol specific conditions, Gloucestershire and England, 2021/22-2023/24[60]

Gloucestershire's rate of under 18 admission episodes for alcohol-specific conditions had not been significantly different to the national average prior to 2019/20 - 2021/22. However, rates in the county increased between 2019/20-2021-22 and 2020/21 - 2022/23 while declining at a national level.

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59 Underage drinking | NSPCC

60 Child and Maternal Health Profile, OHID

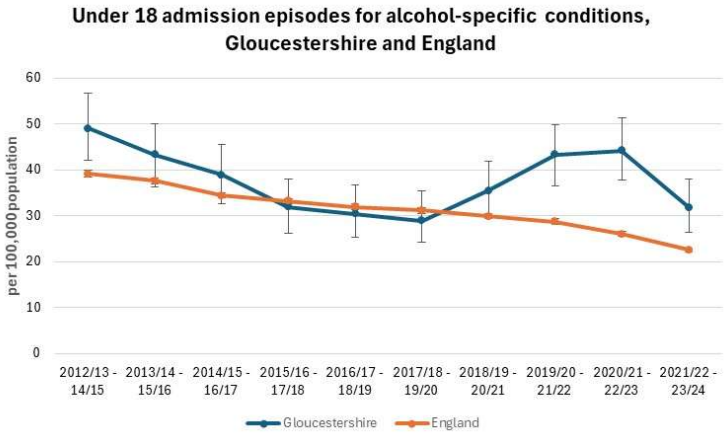


Figure 1411: Under 18 admission episodes for alcohol specific conditions, Gloucestershire and England[61]

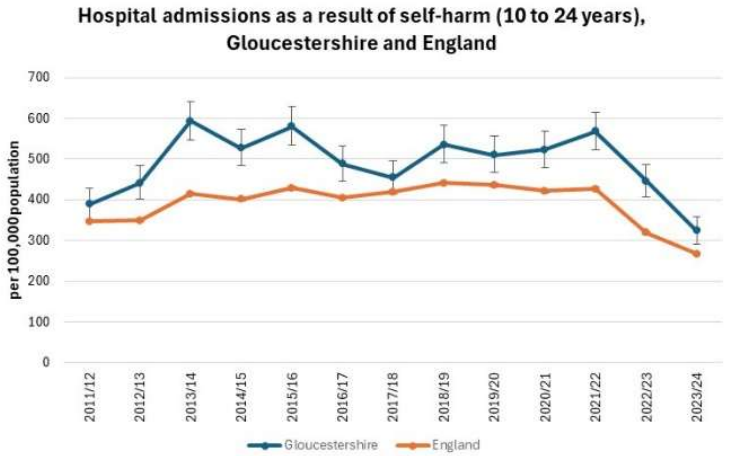


Figure 1512: Hospital admissions as a result of self-harm (10-24 years), Gloucestershire and England[62]

Self-harm

Hospital admissions in Gloucestershire for self-harm among children and young people are significantly higher than the England average (323.8 admissions per 100,000 population compared to 266.6 respectively). Rates in Gloucester are driving the high rate, with 440.3 admissions as a result of self-harm (ages 10-24) per 100,000 population, significantly higher than the county and national average. However, there are signs of improvement with the rate of admissions in 2023/24 being significantly lower than all other periods since 2012/13 (see Figure 15).

Maternity services

Gloucestershire has seen a shift away from midwifery-led births towards obstetric-led births, mirroring national trends. Caesarean births now slightly exceed spontaneous vaginal births for the first time, induction rates are increasing, and the use of midwifery-led birth units are decreasing. The exact reasons for these changes are not fully understood, but are likely linked to shifting demographics, including more women giving birth later in life, higher rates of obesity, and a growing prevalence of preexisting health conditions. There have additionally been changes in guidance to ensure women have an informed choice on mode of birth, including caesarean section.

[61] Child and Maternal Health Profile, OHID

[62] *Ibid*.

The findings of recent health needs assessments highlight persistent health inequalities in postnatal outcomes. Women from deprived areas and ethnic minority communities face disproportionately poorer maternal and neonatal outcomes including increased risks of stillbirth, neonatal mortality, preterm birth, and maternal mortality. They are more likely to encounter barriers to accessing care, including transport difficulties, digital exclusion, and communication challenges.

This is all the more significant as women from ethnic minorities constitute a higher percentage of the maternity population compared to the overall county population. Nearly a quarter of births (23.0%) in 2024/25 in Gloucestershire were to those from ethnic minority communities (including white non-British) and 11.8% of women who birthed in Gloucestershire in 2024/25 did not speak English as their first language. These are both higher proportions than those in the general population in the county.

Inequalities in maternity outcomes

Gloucester experiences some of the county's poorest maternity outcomes, shaped by both deprivation and by a higher proportion of families from ethnic minority communities.

Rates of maternal obesity are rising and are particularly prevalent in areas of higher deprivation. Obesity is associated with a higher risk of complications such as gestational diabetes, hypertensive disorders, prolonged labour, and caesarean section, as well as adverse neonatal outcomes including stillbirth, premature birth, and childhood obesity.

Smoking in pregnancy is also more common in deprived areas. Smoking during pregnancy increases the risk of complications such as low birth weight, premature birth and stillbirth and has long term consequences for child development.

Timely booking (by 10 weeks) and uptake of antenatal education are lower among women from deprived areas and ethnic minority communities.

Breastfeeding protects children from a vast range of illnesses, including infection, diabetes, asthma, high blood pressure and obesity, as well as cot death (Sudden Infant Death Syndrome).[63] However, breastfeeding rates vary across the county and are lowest in Gloucester and the Forest of Dean, as well as among white British women.



[63] Patnode, C., Henrikson, N., Webber, E., et al. (2025) 'Breastfeeding and health outcomes for infants and children: a systematic review', *Pediatrics*, vol. 156 (1), e2025071516. https://doi.org/10.1542/peds.2025-071516

Living Well

- Long-term conditions tend to increase as we age and there are two reasons for this. Firstly, for many conditions such as cardiovascular disease and dementia, the probability of developing the condition increases with age. Secondly, many health conditions are chronic and incurable, meaning levels of illness are cumulative.

The key to healthy ageing is to prevent or delay long term conditions through the adoption of healthy behaviours such as physical activity, healthy diet, and reduction of risky behaviours such as smoking and excess alcohol consumption.

This group covers adulthood, the 'middle years' from leaving school/university through to retiring, including working life.

In 2024, 60.4% of Gloucestershire's population was of working age (ages 16-64), which was lower than the national average of 62.9%. Individuals aged 55-59 and 60-64 made up the largest proportions of Gloucestershire's working age population, which may cause future challenges as these groups look to retire.

Gloucestershire's 16-64 population increased by 6.7% between 2014 and 2024 and was broadly in line with the 6.5% increase at national level.[64]

Looking forward, Gloucestershire's working age population is projected to rise by 14.5% between 2022 and 2047, greater than the growth projected at national (11.0%) and regional (12.2%) levels. These changes will see Gloucestershire's working age population account for a smaller proportion of its total population, falling from 60.6% in 2022 to 59.0% in 2047; driven by an increase in those aged 65+.[65]

Dependency ratio is a measure that indicates what level of support the working population (aged 16-64) need to provide to the younger (aged 0-15) and older (aged 65+) populations. A lower dependency ratio indicates there are more working age people to support the dependent population, a high dependency ratio is the reverse of this.

Between 2022-2047, Gloucestershire's dependency ratio is projected to increase from 0.65 (2022) to 0.69 (2047), meaning for every 100 people of working age, there will be 69 people reliant on them: an increase of four people from 2022.[66]

Foundations for future health

Employment and wages

Evidence shows that work is generally good for both physical and mental health and wellbeing.[67] Positively, employment rates in Gloucestershire are significantly better than the national average. Between October 2024 and September 2025, approximately 82% of

[64] Mid 2014-Mid 2024 Population Estimates, ONS
[65] 2022 based Subnational Population Projections (migrant category), ONS
[66] *Ibid*.

[67] Waddell, G., & Burton, A. K. 2006. 'Is work good for your health and well-being?', Department for Work and Pensions. IS WORK GOOD FOR YOUR HEALTH AND WELL-BEING?

16–64-year-olds were in employment, compared with England's average of 75.8%.[68]

However, there are significant inequalities in employment rates for disabled people in the UK.[69] Furthermore, the gap in Gloucestershire is significantly greater than the national average. This is the gap between the overall employment rate and those in receipt of long-term support for a learning disability and/or those in contact with secondary mental services. A contextual factor within this dynamic is the strong care support sector in Gloucestershire, with institutions such as the National Star College drawing individuals with high needs to come to the county.

In 2025, an estimated 14.1% of employees in Gloucestershire earned below the living wage, in line with the national average. [70] Lower wages severely negatively impact physical and mental health by limiting access to nutritious food, safe housing, and healthcare, while increasing chronic stress and financial anxiety.

Housing

Poor-quality housing harms health; evidence shows that exposure to poor housing conditions (including damp, cold, mould, noise) is strongly associated with poor physical and mental health.[71] Data from the Indices of Deprivation 2025 suggests 26.7% of Gloucestershire's population live in areas amongst the most deprived 20% nationally in terms of indoors living environment (which takes into account housing in poor condition, household energy performance score and housing without access to private outdoor space), increasing to over 45% in Forest of Dean.

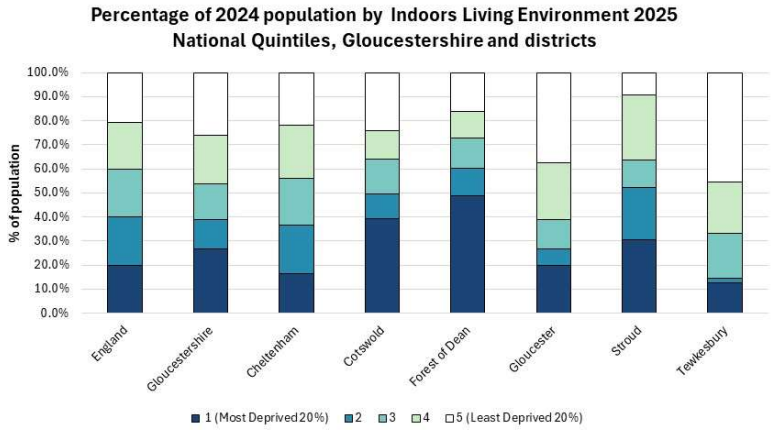


Figure 1613: Percentage of 2024 population by Indoors Living Environment 2025 National Quintiles, Gloucestershire and districts[72]

Furthermore, households with low incomes can struggle to afford adequate heating in the context of high energy prices. [73] Evidence shows that living in cold homes is associated with poor health outcomes and an increased risk of morbidity and mortality for all age groups. 74 In 2023, an estimated 9.8% of households (29,114) in Gloucestershire were living in fuel poverty; however, this was below the national average of 11.4%.[75]

[68] Annual Population Survey, ONS
[69] Improving Lives - The Work, Health and Disability Green Paper, DWP
[70] Living Wage, ONS
[7171] Marmot Review
[72] Indices of Deprivation 2025, MHCLG
[73] UCL Institute of Health Equity (2011). The Health Impacts of Cold Homes and Fuel Poverty
[74] Local action on health inequaltiies: Fuel poverty and cold home-related health problems. Health equity breifing 7. Septeber 2014 PHE and UCL
[75] Fuel Poverty Statistics, Department for Energy Security and Net Zero

The cost of housing can have a significant impact on an individual's health and wellbeing. In 2017, Shelter (England) reported that one in five adults had suffered mental health issues in the last five years due to housing issues.[76] In 2024, an average earner in Gloucestershire (across all districts) needed 8.6 times their income to buy a mid-priced home. This amount is well above the level considered affordable, which is five times earnings locally and 7.5 times earnings at a national level.[77] Housing is most affordable in Gloucester, which has an affordability ratio of 7.3, and is least affordable in Cotswold where that figure rises to 13.8 times earnings.

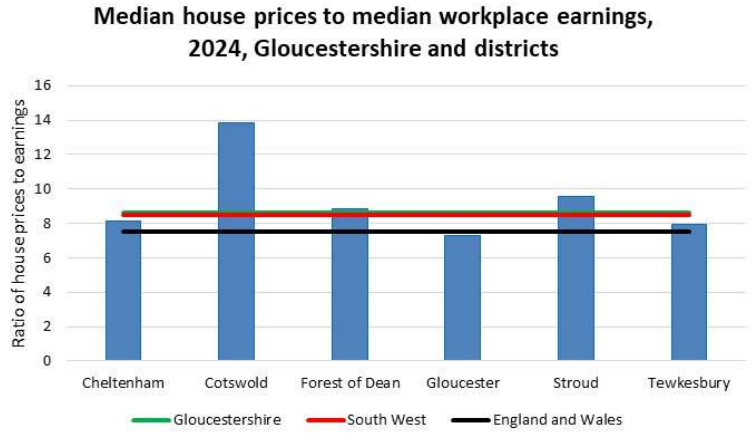


Figure 1714: Median house prices to median workplace earnings, 2024, Gloucestershire and districts[78]

Health behaviours

Physical inactivity

Physical inactivity is the fourth leading risk factor for global mortality, accounting for 6% of deaths globally. People with physically active lifestyles have a 20-35% lower risk of cardiovascular disease, coronary heart disease, and stroke compared to those who have sedentary lifestyles. Regular physical activity is associated with a reduced risk of diabetes, obesity, osteoporosis, colon and breast cancer, and improved mental health. In older adults, physical activity is associated with increased functional capacities. Physical inactivity costs the NHS over £0.9 billion per year. In 2023/24, approximately 72.0% of Gloucestershire's adult population were physically active, which was significantly higher than the national average. Cheltenham and Stroud had significantly higher levels of physical activity than England, while all other areas were similar to national levels.

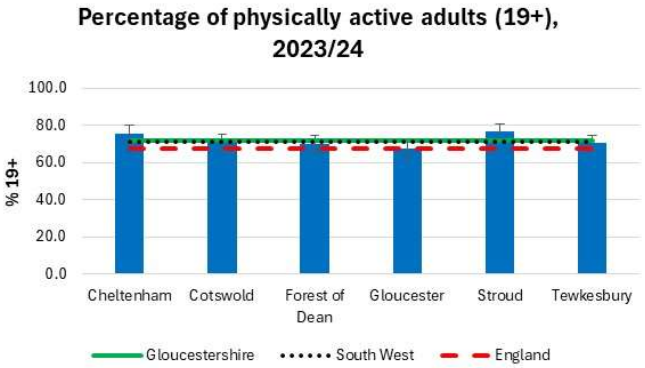


Figure 1815: Percentage of physical active adults, (19+), 2023/24[79]

[76] Shelter, The impact of housing problems on mental health (2017)
[77] House price to workplace-based earnings ratio, ONS
[78] *Ibid*.
[79] *Ibid*.

Obesity

Obesity is a global and complex public health concern. It is associated with reduced life expectancy and is a risk factor for a range of chronic diseases, including cardiovascular disease, type 2 diabetes, at least 12 kinds of cancer, liver, and respiratory disease, and can also impact on mental health. The risk and severity of these diseases increase with a higher body mass index (BMI). The proportion of adults in England living with obesity has seen large increases in the last four decades. In 2023/24, approximately 24.9% (similar to national average) of Gloucestershire's adult population were (based on BMI) classed as obese. The picture at district level is mixed; in 2023/24, Cheltenham and Cotswold had significantly lower levels of obesity than England while all other areas were similar to the national average.

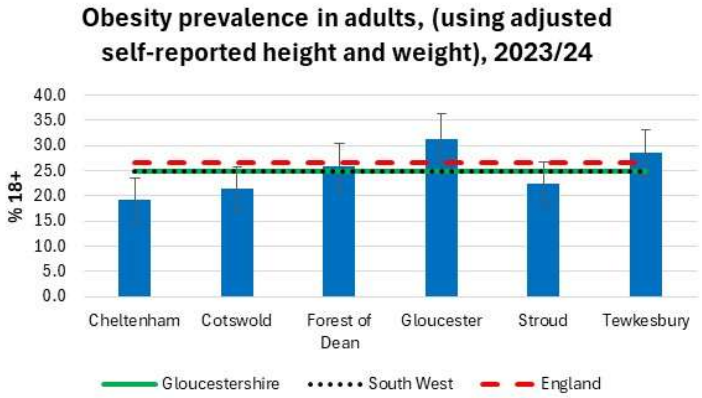


Figure 1916: Obesity prevalence in adults, (using adjusted self-reported height and weights). 2024/24[80]

Smoking

Smoking is the single most important preventable cause of ill health, disability, and death in England. Smoking harms nearly every organ of the body; it causes lung cancer, respiratory disease and cardiovascular disease, as well as many cancers in other organs including lip, mouth, throat, bladder, kidney, stomach, liver and cervix. Smoking puts significant pressure on the NHS. Almost every minute of every day someone is admitted to hospital because of smoking, and up to 75,000 GP appointments could be attributed to smoking each month (equivalent to over 100 appointments every hour). Between 2021-2023, an estimated 11.7% (over one in 10) of Gloucestershire's population aged 18+ were classed as current smokers; similar to the national average of 12.4%. At a district level, Cotswold had significantly lower levels of current smokers compared to England, but all other districts were similar to the national average. When compared to the whole population, people in routine and manual occupations are significantly more likely to smoke at 20.5%, this was in line with the national average of 20.4%.

[80] PHOF, OHID

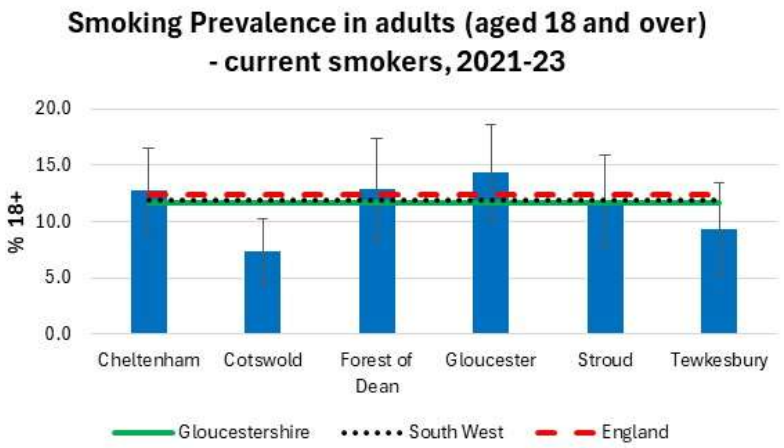


Figure 20: Smoking prevalence in adults (aged 18 and over) -current smokers, 2021-23[81]

Alcohol and drugs

In the UK, alcohol misuse is the biggest risk factor for (premature) death, ill-health, and disability amongst people aged 15-49, and the fifth biggest across all ages.[82] Alcohol contributes towards more than 60 medical conditions, including mouth, throat, stomach, liver and breast cancers; high blood pressure; cirrhosis of the liver; and depression. [83] Furthermore, there are hundreds of thousands of potential working years of life lost (PWYLL) annually due to alcohol-related conditions.[84] In 2024, Gloucestershire saw 1,013 PWYLL due to alcohol-related conditions in males and 366 in females - however, both of these were significantly lower than the national average.[85,]

Drug dependency ruins lives, damages communities and families, and is a major driver of crime. Harms arising from drug misuse are estimated to cost the UK economy £19.3 billion per year.[86] Nationally, 5,565 drug poisoning deaths were registered in 2024, which is the highest number of deaths registered in one year since records began in 1993.[87] However, there has been no significant change in overall drug use in the county compared to 10 years ago. Cannabis remains the most used drug in Gloucestershire (30.3% of the drug treatment population). However, there are rising trends in the use of cocaine, ecstasy and ketamine, so our future activities will need to adapt and take this into account.[88]

Health-related causes of premature mortality

Premature mortality is defined as deaths that happen under age 75. There were 5,664 premature deaths in Gloucestershire between 2022-2024, which equates to a rate of 302.6 per 100,000 population – significantly lower than the national rate of 337.6 per 100,000.[89] Rates

[81] *Ibid*.
[82] The public health burden of alcohol and the effectiveness and cost-effectiveness of alcohol control policies: an evidence review, PHE

[83] PHOF. OHID
[84] Alcohol profile: short statistical commentary, February 2025, OHID

[85] Alcohol Profile, OHID
[86] Government response to the independent review of drugs by Dame Carol Black, Department for Health and Social Care

[87] https://www.gov.uk/government/publications/understanding-organised-crime-estimating-the-scale-and-the-social-and-economic-costs
[88] Drugs and Alcohol Needs Assessment, Gloucestershire County Council
[89] PHOF, OHID.

of premature mortality in Gloucestershire fell significantly following the period 2008-2010 but have remained steady since 2012-2014, except for fluctuations during the Covid years.

Cardiovascular disease (CVD) is a major cause of premature mortality. Treatment and lifestyle improvements have led to sustained reductions in rates of premature mortality from CVD since 2008-2010, but further action around treatment and prevention is needed to continue this progress.

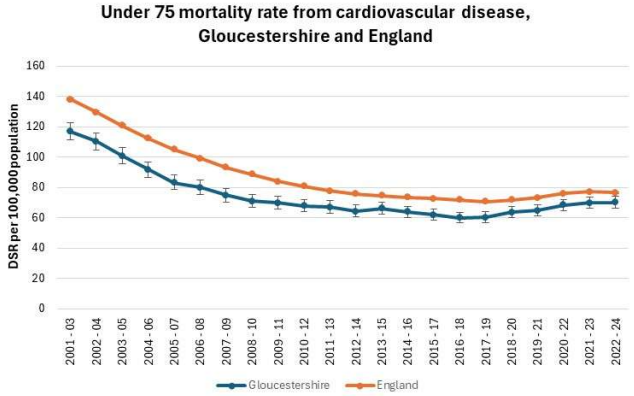


Figure 2117: Under 75 mortality rate from CVD, Gloucestershire and England[90]

In the period 2022-2024, there were 1,326 premature deaths in Gloucestershire from CVD. This equates to a rate of 70.2 deaths per 100,000 population, significantly lower than the national average. The rates vary between districts; in Gloucester, the under 75 mortality rate from CVD was significantly higher than the national average, while rates in Cotswold, Stroud, and Tewkesbury were all significantly lower.

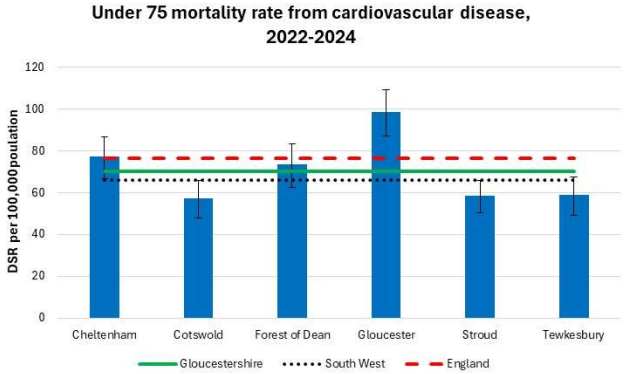


Figure 2218: Under 75 mortality rate from cardiovascular disease, 2022-2024[91]

CVD prevalence is strongly associated with deprivation. Death from CVD makes up 25% of the gap in life expectancy between the most and least deprived areas.[92] However, risk factors such as obesity, physical inactivity, smoking, and drinking at unsafe levels, can all be targeted to help reduce a person's risk of developing CVD. In addition, proper management of the disease can reduce risk of heart failure and cardiovascular events.

The National CVD Prevention System Leadership Forum (CVDSLF) has agreed specific ambitions for the detection and management of high-risk conditions known as 'the ABC':

- atrial fibrillation
- blood pressure
- cholesterol.

[90] *Ibid*.
[91] *Ibid*.
[92] Segment tool, OHID

Atrial fibrillation is a major risk factor for stroke and contributes to one in five strokes. In 2024-2025, 92.1% of patients in Gloucestershire with atrial fibrillation at high risk of stroke were being treated with an oral anticoagulation (similar to the national average of 91%).[93].

Hypertension (high blood pressure) rarely has noticeable symptoms, but if untreated it increases the risk of serious problems such as heart attacks and strokes. Following diagnosis, regular monitoring and a reduction of blood pressure is recommended to reduce serious risk.

In September 2024-2025, 66.8% of patients in Gloucestershire with recorded hypertension had a blood pressure reading in the appropriate treatment threshold; significantly lower than the national average of 70.3%.[94] Ethnic minorities had significantly lower rates of treatment to target than the white population. Deprivation also drove significant differences in access. 60.0% of patients living in the most deprived quintile met the treatment target, compared with 68.3% of those living in the least deprived quintile.

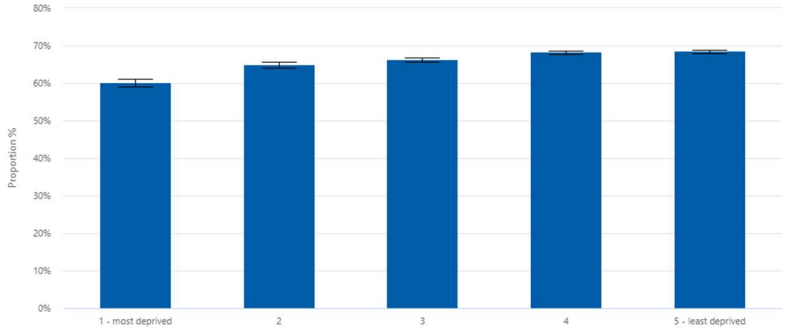


Figure 2319: Patients with GP recorded hypertension, whose last blood pressure reading is to the appropriate treatment threshold, in the preceding 12 months by deprivation quintile. September 2025[95]

High cholesterol can increase the risk of heart attacks or strokes. Lipid lowering therapy with high intensity statins can reduce cholesterol levels and is a clinically effective treatment option- for the primary prevention of CVD. In September 2024-2025, 60.3% of eligible patients in Gloucestershire were treated with lipid lowering therapy, which was significantly lower than the national average of 64.0%.[96]

The NHS Health Check programme aims to help prevent heart disease, stroke, diabetes and kidney disease. Everyone between the ages of 40 and 74, who have not already been diagnosed with one of these conditions, is invited (once every five years) to have a check to assess their risk and will be given support and advice to help them reduce or manage that risk. A high take up of these health checks is important

[94] CVD Prevent

[95] *Ibid.*

[96] CVD Prevent

to identify early signs of poor health, leading to opportunities for early interventions. In 2024/25, 8.4% (16,127 people) of Gloucestershire's eligible population received an NHS health check. This was significantly lower than the national average of 9.0% and a decline on the previous year when the figure stood at 8.7% of the eligible population.[97]



Ageing Well

This section considers the needs of adults aged 65 and over, including multi-morbidity, complexity of need, housing, and wellbeing. In 2024, 22.1% of Gloucestershire's population was aged 65+ (compared to national average of 18.7%), with people aged 65-74 making up the largest proportion at 72,118 people.

Gloucestershire's 65+ population increased by 19.8% between 2014 and 2024, greater than the 15.5% increase at national level and much greater than population increases for children and young people and working age adults.

By 2047, the proportion of people aged 65+ in Gloucestershire is predicted to rise to 26.8% from 21.9% in 2022.[98] This rise is based on projections for Gloucestershire's working age population, which is set to increase by 43.4% in the same period (from 153,038 in 2022 to 205,169 in 2047), higher than England's predicted rise of 38.6%. Looking at the 65+ age group in more detail, the greatest projected increase (at 111.4%) is expected in people aged 85+, which is likely to drive higher demand for health and social care services.

Foundations for future health

Poverty in old age

The combination of poverty and old age creates profound, often irreversible, negative impacts on health: accelerating physical decline, increasing mental health issues, and creating barriers to care.[99]

The Income Deprivation Affecting Older People Index (IDAOPI) 2025 measures the proportion of people aged 60 plus living in low-income households. At a county level, 3.5% of people aged 60+ (6,801 people) live in areas amongst the 20% most deprived nationally – significantly lower than the national proportion of 13.2%. Within the county,

[97] PHOF, OHID
[98] 2022 based Subnational Population Projections (migrant category), ONS
[99] The Relationship Between Poverty And NHS Services | The King's Fund

Gloucester has the largest proportion (at 13.2% or 4,175 people) of people aged 60+ living in these areas. Conversely, Cotswold and Stroud have no older people living in areas within this quintile.

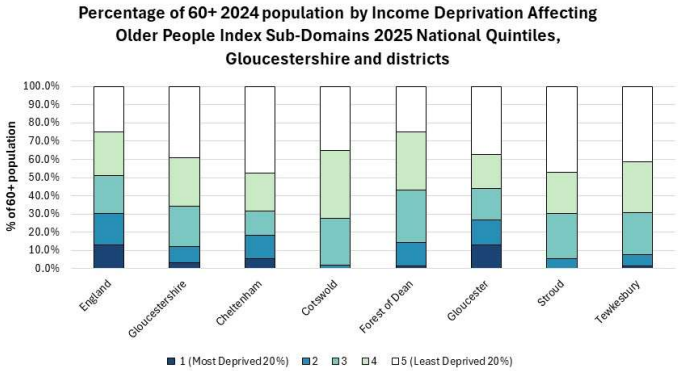


Figure 2420: Percentage of 60+ 2024 population by Income Deprivation Affecting Older People Index 2025 National Quintiles, Gloucestershire, and districts[100]

Loneliness and isolation

Living alone can lead to loneliness and social isolation, which can negatively affect health and well-being. Studies show that loneliness and social isolation are associated with higher risk of health problems such as heart disease and cognitive decline.[101] In 2021, 40,686 people aged 65+ in Gloucestershire were living alone, which equates to 29.1% of this age group.[102] A survey in 2022/23 of Adult Social Care service users estimated that less than half (40.1% or 2,155 people) of individuals aged 65+ had as much social contact as they would like.[103]

Unpaid carers

Providing unpaid care can have significant impacts on an individual's health such as severe physical strain, stress (also due to financial strain), anxiety, and depression, often leading to neglected personal health, and social isolation.[104] In 2021, 9.9% (13,900) of people aged 65+ in Gloucestershire were proving unpaid care. More than 40% of unpaid carers aged 65+ (4.3% of the total age group) provide 50+ hours of care per week.[105]

Falls

Falls are the largest cause of emergency hospital admissions for older adults and significantly impact on long term outcomes.[106] In 2023/24, the rate of emergency hospital admissions for falls in people aged 65 and over stood at 1,531 per 100,000 population, which was significantly lower than the national average of 1,984. However, this rate increases to 3,814 per 100,000 population among people aged 80+, although remaining significantly below the national average.

Flu vaccination uptake

Flu vaccination for people aged 65+ is crucial as ageing weakens the immune system, making older adults more vulnerable to severe flu, hospitalisation, and death. In 2024/25, flu vaccination coverage among people aged 65+ in Gloucestershire stood at 80.8%, significantly higher than the national average of 74.9% but still lower than the national ambition of 85%.[107]

[100] Indices of Deprivation 2025, MHCLG and Mid 2024 Population Estimates, ONS
[101] Loneliness and Social Isolation — Tips for Staying Connected | National Institute on Aging
[102] 2021 Census, ONS
[103] PHOF, OHID
[104] soc23-health-report_web.pdf
[105] 2021 Census, ONS
[106] Public Health Outcomes Framework 2013 to 2016 - GOV.UK
[107][107] PHOF, OHID

How People Access Health and Care

Population segmentation by health needs

We have undertaken work to understand our local population health by dividing the Gloucestershire population into segments. We have used the Johns Hopkins Model with 11 distinct groups that are defined by the complexity and intensity of healthcare needs.

Our population health modelling shows that of the patients registered with a GP Practice in Gloucestershire, 73% (508,381) are currently living with low health need compared to 24% (166,184) in moderate health need and 3% (22,815) with high health needs – either people living with highly complex multi-morbidities or older people over 65 living with frailty.

Health Group	No. of people	% of Pop.	Low/Med/High
01: Non-User	38,208	5.48%	Low Need: 508,381 (72.9%)
02: Low Need Child	105,685	15.15%	
03: Low Need Adult	237,226	34.02%	
04: Multi-Morbidity Low Complexity	127,262	18.25%	
05: Multi-Morbidity Medium Complexity	84,938	12.18%	Moderate Need: 166,184 (23.8%)
06: Pregnancy Low Complexity	6,905	0.99%	
07: Pregnancy high Complexity	1,713	0.25%	
08: Dominant Psychiatric/Behavioural Condition	12,669	1.82%	
09: Dominant Major Chronic Condition	59,959	8.60%	
10: Multi-Morbidity High Complexity	14,145	2.03%	High: 22,815 (3.3%)
11: Frailty	8,670	1.24%	
Total	**697,380**		

Figure 25: Proportion of the Gloucestershire population divided by health groups

How people use health and care services in Gloucestershire

Dividing the population into these groups also helps us to understand trends in how residents access health and care services in the county.

	Percentage of Population	Primary Care	Community Care	Mental Health	111	MIU	ED Attendance	Emergency Admission	Elective Admission	Outpatient Procedure	Outpatient Appointment	Non-Elective Bed Days: All Providers
01 Non-User	5.48%	0.06	0.03	0.01	0.02	0.02	0.02	0.00	0.00	0.03	0.04	1.05
02 Low Need Child	15.15%	2.23	0.64	0.19	0.18	0.16	0.21	0.03	0.02	0.10	0.40	1.09
03 Low Need Adult	34.02%	2.67	0.12	0.04	0.09	0.09	0.10	0.02	0.02	0.09	0.28	1.48
04 Multi-Morbidity Low Complexity	18.25%	6.87	0.55	0.10	0.18	0.13	0.21	0.09	0.11	0.26	0.89	2.43
06 Pregnancy Low Complexity	12.18%	11.41	1.15	0.14	0.26	0.19	0.35	0.21	0.31	0.61	2.06	4.38
08 Dominant Psychiatric/Behavioral Condition	0.99%	7.27	1.49	0.19	0.37	0.09	0.30	0.14	0.06	0.96	3.65	2.64
05 Multi-Morbidity Medium Complexity	0.25%	12.56	2.47	0.74	0.74	0.16	0.72	0.49	0.13	1.63	6.26	3.43
09 Dominant Major Chronic Condition	1.82%	10.51	1.05	5.35	0.53	0.19	0.53	0.16	0.13	0.28	1.38	4.01
07 Pregnancy High Complexity	8.60%	11.42	2.01	0.45	0.26	0.15	0.30	0.20	0.50	0.67	3.10	5.10
10 Multi-Morbidity High Complexity	2.03%	21.18	8.58	1.28	0.87	0.32	1.31	1.16	1.25	1.54	6.62	15.70
11 Frailty	1.24%	23.55	20.46	1.39	0.93	0.18	0.94	0.77	0.34	0.75	2.55	31.02

Figure 26: Number of contacts per person per year for each of the population segments in Gloucestershire

Our population modelling shows that demand for healthcare grows significantly as health deteriorates. People in good health have between 2-3 contacts per person per year across all healthcare services. However, this increases to between 15-20 contacts for people in higher need groups, such as multi-morbidity with high complexity and frailty groups.

Demand is higher in areas such as primary and community settings for people with more health complexity. For example, people living with complex multiple long-term conditions or older people living with frailty have 23 contacts per person per year in primary care and a similar number in the community. Both groups also account for a significantly higher use of Emergency Department attendances and admissions (per person per year) than all other groups.

These two groups (making up just over 3% of the population) account for 60% of non-elective bed days in our acute hospital. Similarly,

outpatient appointments are high for people living with complex multiple long-term conditions (almost 7 per person per year).

Projected changes in population health and care needs

Both population growth and changes in the age profile of the population are projected to change the proportion of residents between the need groups. We know that the prevalence of long-term conditions will increase. The probability of developing many conditions (such as cardiovascular disease and dementia) increase with age. Furthermore, since many health conditions are chronic and uncurable, the levels of illness are cumulative.

Our population health modelling shows that the greatest growth will be amongst people with high health needs – older people living with frailty (46% percentage increase from 2025 to 2040) and people living with complex multiple long-term conditions (30% percentage increase).

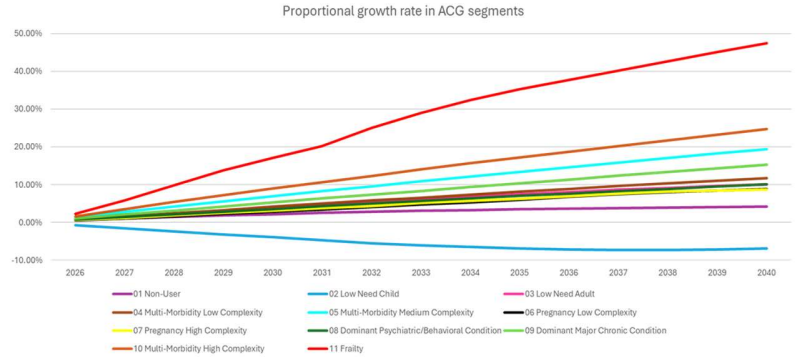


Figure 27: Changes in proportion of need groups within the population

However, this rate of growth is not inevitable. Around 1 in 5 deaths in England are avoidable, a similar pattern to Gloucestershire. Of these, 65% are preventable deaths (could be prevented by public health measures and/or individual lifestyle choices) with the remaining 35% considered treatable (could be prevented with timely and effective healthcare). Avoidable mortality is higher in more deprived areas. The Global Burden of Disease Study from 2021 showed that the greatest risk factors by cause of death in Gloucestershire were high blood pressure, tobacco and dietary risks.

Similarly, whilst premature death (mortality occurring under the age of 75) is lower in Gloucestershire compared to England, there are areas where further attention is needed. For example, people under 75 living with severe mental illness in Gloucestershire are over five times more likely to die prematurely than the general population.

Analysing our population in this way points to areas for investment which can make a real difference in the population outcomes, by targeting resources into condition management and prevention towards those at risk of moving into higher-need groups and thereby slowing the 'drift' of people moving through these groups. If successful, such prevention would significantly improve the quality of life of those individuals in that group, and the level of demand on the healthcare system as a result.

How People View Health and Care Services

In addition to data concerning population health needs, it is important that strategic commissioning decisions are also guided by an understanding of what matters to local people (both the public and our staff) in Gloucestershire. We have a long history in Gloucestershire of public engagement about how and where we deliver services.

Between November 2025 and January 2026, we undertook engagement with the public to listen to their views on the current challenges with the local NHS, and the opportunities ahead. **Getting Ready for the Future NOW!** was our engagement plan, focusing on questions aligned with the three 'shifts' in the national 10 Year Health Plan. These were:

- Neighbourhood health and care
- Online digital and technology
- Wellbeing, prevention, and maintaining health independence.

A full report on the findings from this engagement can be found at Get Involved in Gloucestershire. As this report gives a comprehensive analysis of the insights generated, for the purpose of this needs assessment we will provide a summary of the findings and would direct readers to the report for more detail.

Who was involved?

Information and opportunities to get involved were shared via our online participation space – Get Involved in Gloucestershire. Engagement booklets were distributed through GP Practices, local hospitals, community hubs, libraries, children's centres, and leisure centres across the county. Information was shared widely with



Integrated Locality Partnerships, Know Your Patch networks and other community partners. We also sent the survey to members of the One Gloucestershire People's Panel.

The Engagement Team visited community venues and joined the Information Bus in areas across the county. We also spoke with voluntary sector representatives, Patient Participation Groups, Young Influencers and people from underserved communities.

In total, we received 499 responses to the survey, with additional themes arising from direct engagement with the public and groups described above.

Summary of findings

We have grouped insights from the engagement into three themes:

Theme 1: Wellbeing, prevention, and digital access

What we heard:

- Significant numbers of people are not aware of local activities to support their health.
- People see an important role for voluntary sector organisations in helping with people's health and wellbeing.
- Some people are concerned that the shift to digital means these become the norm (rather than face-to-face).

Theme 2: Healthcare services today

What we heard:

- People generally reported receiving good care.
- People want consistent and timely access to GP services and lower treatment waiting times.
- People value face-to-face information sharing and group discussions.

Theme 3: Designing healthcare for the future

What we heard:

- People want the services they use regularly to be close to where they live.
- People want care at home, even if this means reducing hospital bed numbers.
- People want quick assessment and 24/7 access for urgent care more than local services.
- People want expertise and low waits for a specialist more than having fewer appointments, or to have these services close by.



Headline Messages for Commissioning

The purpose of this needs assessment has been to provide insights and analysis to inform commissioning decisions for Gloucestershire over 2026/27. To this end, we have highlighted below a set of key messages from this report that should be used to inform strategic commissioning decisions:

Theme 1: Gloucestershire performs well overall, but there are inequalities within the county

While outcomes are strong overall, areas such as Gloucester, parts of Cheltenham, and some rural areas experience poorer life expectancy, higher burden of disease, and greater barriers to services. Investment should focus on communities with the poorest outcomes to close the gap and ensure system resources are aligned to need. Future commissioning should target enhanced prevention, improved access pathways, and integrated locality-based models in these communities. Working with system partners to address structural issues – such as transport, digital exclusion, and housing – will also be critical.

Theme 2: An ageing population brings increased demand and needs

Commissioners will need to plan for sustained growth in multimorbidity, frailty, and complex care needs as the population ages. The projected rise in those aged 65+ and 85+ indicates mounting pressure on primary care, community services, urgent care, and social care. Commissioning decisions should therefore strengthen early intervention, multidisciplinary community teams, reablement, and proactive management of long-term conditions to lessen the pressures on secondary care and enable individuals to receive care closer to home. Workforce planning, particularly in community and domiciliary care, will be essential to meet rising complexity and support people to live independently for longer.

Theme 3: Opportunities to target resources to improve healthy life expectancy

Commissioners should focus investment on prevention and early detection to slow progression into higher-need groups and reduce avoidable demand. Targeted approaches are needed in communities with high levels of preventable ill health, particularly relating to cardiovascular disease, smoking, obesity, and physical inactivity. Expanding evidence-based interventions – such as NHS Health Checks, condition management programmes, behavioural risk reduction, and accessible lifestyle support – will deliver significant long-term benefits for healthy life expectancy on a population level. A population-health approach that concentrates resources where risk is highest will improve healthy life expectancy, reduce inequalities, and lessen future system pressures. Strengthened partnerships with voluntary and community sectors will be key enablers.