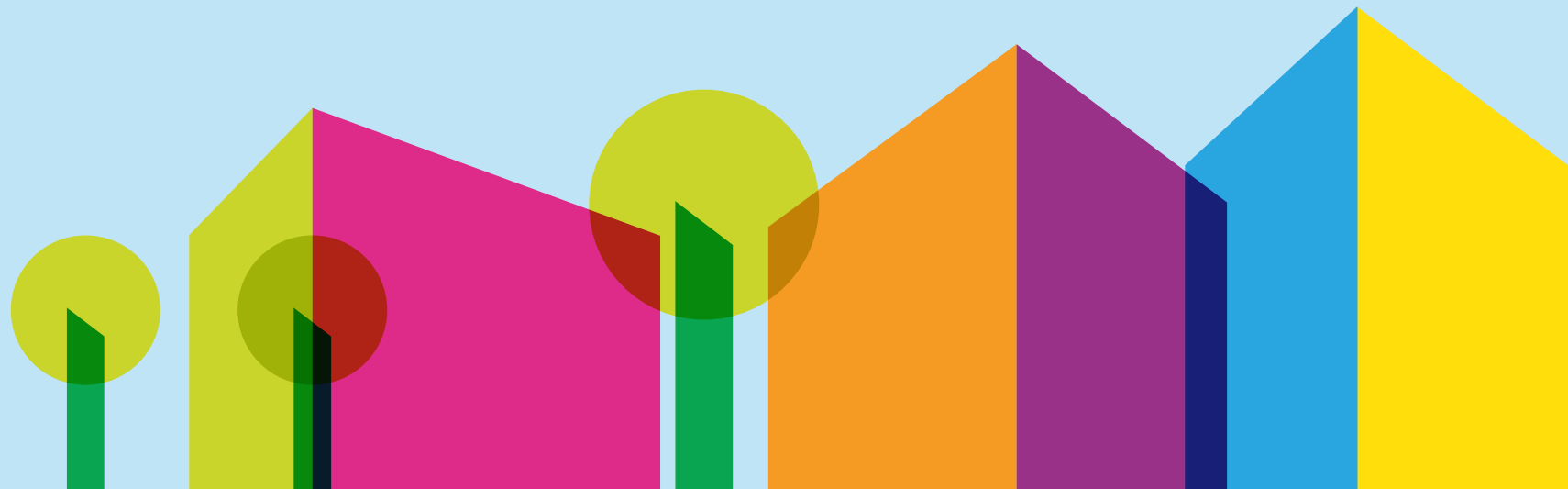


An overview of health across the Liverpool City Region

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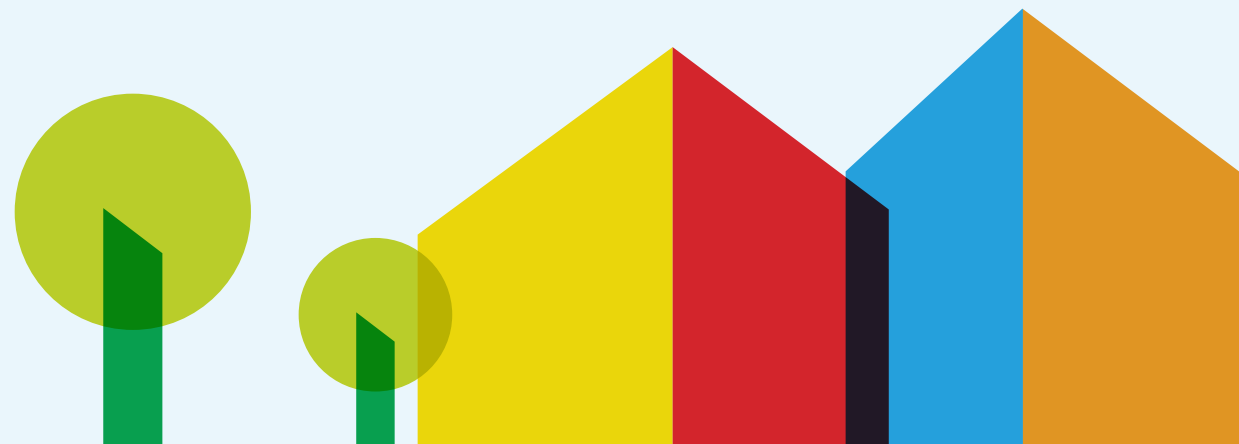
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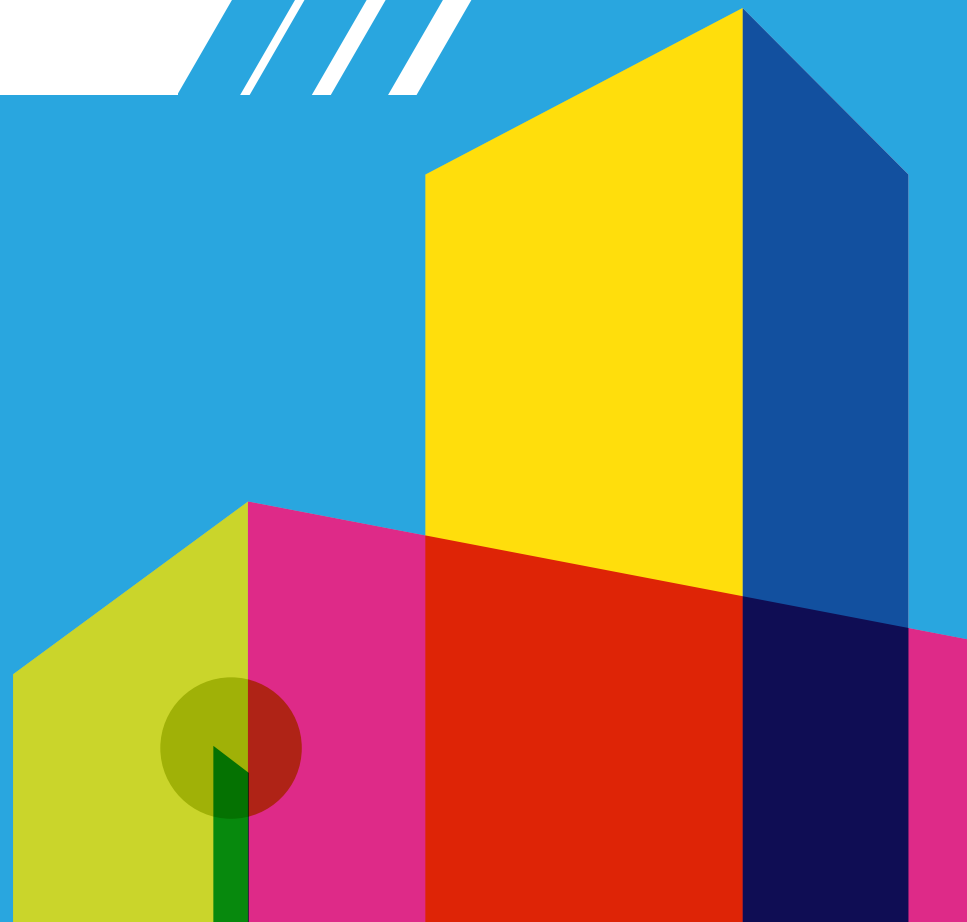
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1. Review of key aspects

of the built and natural environment and health and their relation to the data on health in the Liverpool City Region



Introduction

Health and wellbeing across the Liverpool City Region population is heavily influenced by the social determinants of health. Life expectancy, premature mortality, prevalence of ill health, both physical and mental, tends to follow the distribution of deprivation across the city region, within the boroughs and in comparison between the city region and England as a whole.

All six of the city region's boroughs are worse off than the England average on the national index of multiple deprivation. In addition to the long-standing poor health associated with deprivation, the pandemic has hit the local economies hard. Of all those in employment in the Liverpool City Region, 28% were furloughed at some point during the pandemic and the claimant count rose by 54%, from 41,505 in March 2020 to more than 63,110 in August 2021. The pandemic has had an effect to exacerbate the poor health in the city region and to widen the inequalities in health.

Many of the social determinants of health are affected by the built environment, and by extension, the planning process. These include access to open and green space, air

and environmental quality, access to public transport, ease of walking and active travel and housing. The planning system can maximise the opportunities to support the long-term health of the population in the city region by regulating, promoting or restricting certain land uses.

Five key aspects of the built and natural environment and health; namely neighbourhood design, housing, healthier food, natural and sustainable environment and transport will be reviewed to draw out the links to health and wellbeing and the city region.

Summary

The health profile for each of the six boroughs in the city region and the profile for the city region overall showed a number of common features that can be related to elements of the spatial planning remit. The common features include

- Lower life expectancy and healthy life expectancy than the England average
- The main causes of premature mortality are cardiovascular disease, cancers and respiratory illness

- Higher levels of obesity than the national average in children and adults
- Lower levels of engagement in physical activity and more people not taking exercise than the national average
- Higher levels of mental ill health than the England average
- High numbers of older people hospitalised through falls
- Lower than average consumption of fresh fruit and vegetables

As mentioned in the introduction, many of the above population health features are distributed across the city region in line with social determinants of health such as deprivation, educational achievement and average earning. This review focuses on the factors within the remit of spatial planning that can have an impact on health and wellbeing in the Liverpool City Region.

Each of the following sections summarises the evidence linking an element of spatial planning with health issues in the city region. Neighbourhood design is the first of the five elements summarised. The design of a neighbourhood can contribute to the health and well-being of the people living there. Several aspects of neighbourhood design (walkability and mixed land use) can also maximise opportunities for social engagement and active travel.

High quality housing is essential for good health with respiratory illnesses an obvious association with health. However improved mental health is also associated with the removal of fuel poverty.

A household is in fuel poverty if they are on a low income and face high costs of keeping adequately warm and other basic energy services. Fuel poverty is driven by three main factors: household income, the current cost of energy and the energy efficiency of the home. A systematic review of the evidence linking fuel poverty and health indicates cold conditions and fuel poverty may have a moderate effect on adult physical health, but a significant effect on the mental health of adults and young

people, children's respiratory health, as well as infant weight gain and susceptibility to illness. Evaluation of the government's Warm Front scheme found increases in room temperature were associated with reduced likelihood of experiencing depression and anxiety. Another study found that young people living in cold homes were more likely to be at risk of multiple mental health symptoms.

Access to healthier food is associated not just with the possibility of increasing fruit and vegetable consumption but also with supporting active travel and social interaction.

Air quality is an issue that features under natural and sustainable environment and the evidence for association with a range of illnesses, such as asthma and other respiratory illnesses, has been growing over the last decade. Finally, transport is linked with health in many ways. Access to transport is essential for social interaction and access to public facilities and work.

The type of transport that is prioritised in planning can add to poor air quality if car-based transport is the default priority or could promote physical activity if active transport is prioritised.

The table below summarises the association between the planning characterises on the left side with the planning principles, their impact on health and wellbeing and the expected health outcomes on the right side.



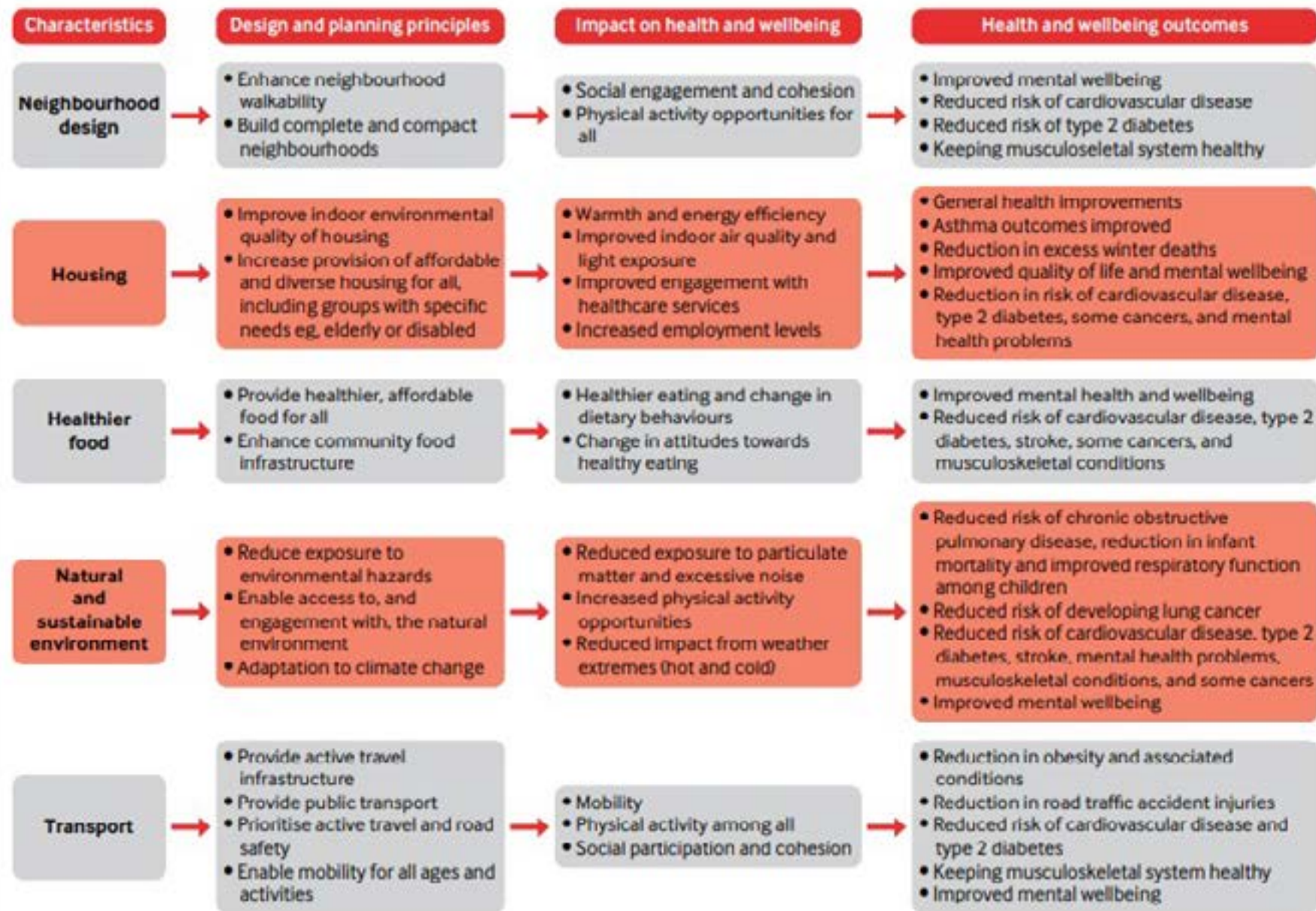


Fig 1 | Associations between design and planning principles and health and wellbeing (adapted from Public Health England's Spatial Planning for Health)¹⁰

Source: British Medical Journal

Spatial planning in the Liverpool City Region can have an impact on social isolation, community participation, levels of physical activity, access to fresh food, the quality of air people breathe and mental health. Positively influencing these factors in favour of health is associated with reducing the risks of the main causes of premature mortality in the city region and improving the overall mental health of the population. Improvements in those health outcomes can improve life expectancy and healthy life expectancy for people in the Liverpool City Region.

Neighbourhood design

Neighbourhoods are places where people live, work, and play and have a sense of belonging. The design of a neighbourhood can contribute to the health and well-being of the people living there. Several aspects of neighbourhood design (walkability and mixed land use) can also maximise opportunities for social engagement and active travel. Neighbourhood design can impact on our day-to-day decisions (like where we eat, spend our free time and who we meet) and therefore have a significant role in shaping our health behaviours.

Numerous studies point to the direct benefits of **green space** to both physical and mental health and well-being. Green spaces have been associated with a decrease in health complaints, blood pressure and cholesterol, improved mental health and reduced stress levels, perceived better general health and the ability to face problems. There is strong evidence that provision of green space effectively improves mental health and less strong/inconclusive evidence that it improves levels of physical activity.

One study has shown that in areas in England with more green spaces the gradient in deaths from circulatory disease by income deprivation is reduced – this suggests that the amount and the distribution of green space has great potential to reduce health inequalities. The quality of green space is very important for health. Access to poor quality green space doesn't show the same benefits.

Green space also encourages social contact and integration, provides space for physical activity and play, improves air quality and reduces urban heat island effects, which also helps mitigate against the impacts of climate change. Given the strong evidence around the relationship between green space, health and well-being,

it is notable that there is a significant difference in the frequency of different classes visiting a green space. Over 35% of those in the poorest socio-economic group visit green spaces infrequently (less than once a month). This is likely to be due to both the low availability and bad quality of green space in deprived areas. The open space on social housing estates is often insufficient and unsatisfactory - currently less than 1% of people living in social housing report using the green space on their estate.

In some cases, **community participation and social isolation** are heightened by the physical environment, especially for elderly and disabled people: the design of neighbourhoods, in particular street crossings, legibility and the quality of spaces can stop many vulnerable people from leaving the home. Fear of crime in public spaces and fear of traffic often stops elderly people from reaching services and community groups and taking advantage of interaction with neighbours and local retailer in public spaces and shops.

Social networks and participation act as protective factors against cognitive decline and dementia for those over 65. They also aid recovery of those who fall ill and therefore reduce the

risk of death. These patterns are reinforced by the negative effects of social isolation – those who are socially isolated are between two and five times more likely to die prematurely when compared to those with strong social ties. Social isolation can cause stress and depression, particularly for those with young children and older people. 19% of people in the most deprived areas of England have a severe lack of social support compared to 12% in the least deprived quintile.

The way that neighbourhoods are laid out can positively affect health. Mixed land use promotes physical activity, as people are more likely to walk or cycle to go to work, go shopping, or spend their free time if destinations are in their local area. Living in an activity-friendly neighbourhood can provide 32-59% of the 150 minutes of weekly physical activity that is recommended for adults to maintain good health. Ideally, all basic amenities should be located no further than 5 minutes walk away from where people live. It is important that people find it easy to move about their local environments. This extends to accessibility problems for those who are disabled or the elderly population.

Enhancing neighbourhood walkability, building complete and compact neighbourhoods and enhancing connectivity with safe and efficient infrastructure is associated with improvements in mental wellbeing and decreasing risks of cardiovascular disease, diabetes, mental health problems, musculoskeletal problems and some cancers.

Housing

A considerable amount of time is spent daily in the home. Housing is a basic human right and the quality and affordability of houses can determine the health status of residents. It is estimated that 20% of the UK's housing stock does not meet decent home standard and that the cost to the NHS of poor-quality housing is £2.5 billion per annum. Living in good quality and affordable housing is associated with numerous positive health outcomes for the general population and those from vulnerable groups.

Over the past 20 years, the poorest groups have become concentrated in social housing, and the association between social housing and negative outcomes applies across several areas including health, education, self-efficacy and income. A study

suggested that children in bad housing are more likely to have mental health problems, such as anxiety and depression, to contract meningitis, have respiratory problems, experience long-term ill health and disability, slow physical growth and delayed cognitive development.

For many people, the shortage of affordable housing poses the greatest threat to health. Many are either homeless or forced to wait for new homes in unsuitable conditions, often due to a lack of housing. The bottom end of the private rental sector often offers poor housing conditions at high rents, where disadvantaged people often find it impossible to ensure basic maintenance of the property. The provision of affordable housing for the homeless has consistently been shown to increase engagement with healthcare services, improve quality of life and increase employment. It has also been shown to contribute to improvements in mental health status.

Overcrowding is also detrimental to health, in particular mental health – this is also caused by the shortage of affordable housing, with a lack of large properties for families in the social rental sector and unaffordable private rents for those with large families.

Overcrowding became a prominent factor in the transmission of Covid especially multi-generational ethnic minority families in poorer areas.

Cold, damp housing is also a risk to health, affecting the levels of winter deaths and respiratory diseases. Approximately 33% of the poorest fifth of households are in fuel poverty, compared to less than 1% of the richest fifth of houses. Evaluation of home insulation programmes concluded that targeting home improvements at low-income households significantly improved social functioning, as well as physical and emotional well-being.

Adequate heating systems improve asthma and reduce the number of days off at school which in turn can contribute to better educational attainment in the long term. There is evidence to suggest that living in a warm and energy efficient property can improve general health outcomes, reduce respiratory conditions, improve mental health and reduce mortality.

Improving the energy efficiency of housing across the social gradient would go some way to decreasing the fuel poverty of households in deprived areas, although increases in income are also necessary. It also decreases energy related emissions which helps

to tackle climate change and has positive health impacts.

Extreme weather conditions, both hot and cold, are a particular risk to health and have an impact on inequality, because of the spatial distribution of people on low incomes, who are more likely to live in areas which are warmer during the summer months, more exposed to weather extremes and to flooding. It is likely that continuing climate change will exacerbate these problems with the greater impact falling on people living in more disadvantaged circumstances.

Good quality housing can also reduce the risk of unintentional injury or death. For example, improvements to residential lighting and interventions to reduce hazards in the home can lead to improved social outcomes and reduce fall-related injuries among older adults.

The location of neighbourhoods is also relevant. Housing can too easily end up in unsuitable and isolated areas where there are no local shops, services or jobs, and little potential for social cohesion which often forces residents into cars. Higher residential density is associated with higher levels of physical activity, however within an area there should also be green space and a mix of buildings in order

to enable the easy use of services as outlined in the first part of this section. Additionally, buildings should not be planned around car use, and instead it should be ensured that there is access to high-quality public transport within a 1km, or a 10-15 minute walk.

Improving the quality of housing and increasing the provision of affordable and diverse housing is related to improvements in wellbeing and general health, reduction in fall related injuries in older adults, reduction in prevalence of chronic health conditions (cardiovascular disease, respiratory illness and some cancers) and reduction in excess winter deaths.

Healthier food

The food environment plays an important role in promoting a healthy diet, but this is a complex system influenced and determined by a series of factors, including a person's proximity to food retail outlets and the type of food available. Vulnerable groups, including those on a low income, children, young people, those who are overweight or obese, and those of certain ethnicities, are less likely to achieve a healthy and balanced diet. Existing evidence indicates that making healthier foods more accessible and increasing

provision of low-cost healthier food could be effective interventions, but these are likely to be more effective as part of a whole system approach to diet and obesity.

Research indicates that increased access to unhealthier food retail outlets is associated with increased weight status in the general population, and increased obesity and unhealthy eating behaviours among children residing in low-income areas. A consistent body of evidence suggests that provision of healthy, affordable food in schools is associated with improved healthier food sales, dietary behaviours and nutritional outcomes. A UK based study found that exposure to takeaway food outlets was associated with consumption of takeaway food, particularly around the workplace.

Low income and area deprivation are both barriers to purchasing fresh or unfamiliar foods, while lower income households are the harder hit by food price fluctuations. There are indications that residents in deprived areas in low-mobility groups could benefit from interventions aimed at increasing their access to better shopping facilities.

The mix of shops in deprived areas tends to be weighted towards fast

food chains and other unhealthy food options, making it harder to access healthy food, particularly fresh produce. One study showed that per capita provision of fast-food outlets was four times higher in the most deprived areas compared to the least. Perhaps partly because of this, and food deserts (the unavailability of local food shops), low-income groups are more likely to consume fat spreads, non-diet drinks, meat dishes, pizzas, processed meats, whole milk and table sugar than higher income groups. This affects levels of obesity in the population.

The purpose of many local journeys is shopping for food supplies as well as other basic items such as household cleaning supplies and clothing: a lack of local food shops can decrease rates of active travel, as people are forced to drive to buy their food and other supplies. The presence of retail uses within an area and sustainable local economies is vital to provide for an environment that allows for active travel opportunities.

Residents of deprived areas could particularly benefit from policies which aim to improve availability of healthier food options and better access to shopping facilities. Having local shops within walking distance and generally

high accessibility to shops which stock healthy food is likely to improve health within these areas, especially when coupled with planning restrictions on the density of fast-food outlets within deprived areas. Findings from a recent literature review suggest that gardening in an allotment setting in the UK may result in numerous positive physical and mental health-related impacts and outcomes.

The provision of healthier, affordable food for the population and enhanced community food infrastructure is associated with maintenance of healthier weight in children and adults, reduced risk of cardiovascular disease and improved mental wellbeing.

Natural and sustainable environment

There is a very significant and strong body of evidence linking contact and exposure to the natural environment with improved health and wellbeing. Environmental inequalities impact on health and wellbeing, and act with other factors to reinforce health inequalities. People who live next to environmental benefits such as good quality green spaces, enjoy better air, less noise and access to natural spaces. People who live in the vicinity of polluting factories, major roads or

railway lines inevitably suffer from the related noise and air pollution.

The evidence of the distribution of environmental burdens across the social scale highlights the disproportionate impact of environmental burdens on disadvantaged groups. In particular, poor housing, higher rates of crime, poorer air quality, lack of green spaces and places for children to play, and more risks to safety from traffic as well as the negative effects of climate change.

In the least deprived areas, over 70% of the population experience no unfavourable environmental conditions, compared to less than 30% in the most deprived areas.

There is clear evidence of the adverse effects of outdoor air pollution, especially for cardiorespiratory mortality and morbidity. Poorer communities tend to experience higher concentrations of pollution and have a higher prevalence of cardiorespiratory and other diseases. 66% of cancer-causing chemicals emitted into the air are released in the 10% most deprived wards. There is strong evidence that reductions in traffic to reduce air pollution are successful in improving health.

Air pollution correlates well with noise pollution, especially in areas where air pollution is caused by car or air traffic. Noise pollution therefore often adds to the environmental burden shouldered by poorer sections of society - studies have shown that noise pollution is worse in areas of high-density housing, rented accommodation, areas of deprivation and areas which are highly urbanised.

It has also been demonstrated that noise pollution has adverse effects on mental health. Exposure to excessive noise is associated with poorer mental health outcomes, particularly among older adults and children. It is also linked with higher anxiety levels among adults and increased stress and hypertension in adults.

Reduced exposure to environmental hazards is linked with decreased risk of cardiovascular disease, diabetes, respiratory diseases and some cancers, including lung cancer. Access to and engagement with the natural environment is also linked to reduced risk of chronic illness and improved mental health outcomes.

Transport

Transportation plays an important role in supporting daily activities. Transport, including walking, cycling, driving and public transport, is essential to the health and wellbeing of a community. Active travel (cycling, walking and use of public transport) can increase physical activity levels and improve physical and mental wellbeing. Prioritisation of active travel can also reduce over reliance on motorised transport, contributing to improved air quality and a reduction in road injuries.

There is a wealth of high quality evidence to show that investing in infrastructure to support walking can increase physical activity levels and improve mobility among children, adults and Older adults.

Transport accounts for around 29% of the UK's CO2 emissions. The relationships between transport and health are multiple and complex, and transport also provides access to work, education, social networks and services, which can improve people's opportunities.

The impact of transport on health inequalities is greatest when looking at deaths from road traffic injuries, especially for children. The single

major avoidable cause of death for children over five is unintentional injury on the roads. The social class gradient in injury across all ages is steeper than for any other cause of death or long-term disability. Furthermore, rates of child death from unintentional injury have not declined in families in which no adult is in paid employment, despite overall reductions. The inequalities are indisputable - children in the 10% most deprived wards in England are four times more likely to be involved in a road accident than children in the 10 % least deprived wards. Fatal accidents on the road are also particularly high among children of parents classified as never having worked or as long-term unemployed.

The proportion of people cycling (and therefore likely to be benefiting from the associated health improvements) follows a clear social gradient. The lower the social grade of a person, the less likely they are to cycle. Where interventions have taken place to improve cycling rates, they have tended to focus on the whole population of selected areas rather than looking at the distribution of cycling across the social gradient.

Interventions to encourage active travel include investing in better walking and cycling routes, reducing

car speed to improve road safety, and improving public transport. Places that promote active transport (walking and cycling) and provide effective public transport are likely to improve health, cut carbon emissions, and improve community cohesion.

Walking is encouraged by the presence of safe, traffic free, and well-maintained walking routes, and large, public open spaces. As well as the road design principles discussed above, road crossings should be modelled around pedestrians – designers should assess not only if a pedestrian is able to cross the road safely but if the route creates delays or takes them away from their natural walking route.

As with walking, cycling is also promoted by safe, traffic free and well-maintained cycle paths, as well as the presence of sufficient cycle parking spaces. Walking and cycling will both be encouraged by less traffic, moving at a slower speed. This would also cut traffic accidents on the roads. Many studies have suggested a 20mph speed limit in residential areas. It is also important that 20mph zones should be area-wide as effects are much greater this way, (compared to when only some roads are included).

Effective public transport can allow people to access services and improve community cohesion. It can also increase active travel – people are often willing to walk to get to good public transport links, such as light rail stations.

The provision and promotion of an active travel infrastructure such as walking and cycling lanes away from cars, the provision of efficient public transport and prioritisation of active travel is associated with decreased risk of cardiovascular disease, diabetes, promotion of mental wellbeing and reduced risk of pedestrian injury and road traffic collisions.



Conclusion

Many factors come together to influence the health of a population and to produce the inequalities in health that are evident in Liverpool City Region. It follows then that action to improve health and reduce inequality has to be multifactorial. The social determinants of health are the key factors that have a long-term effect on a population health profile.

The land use planning process and [Fuel Poverty and cold home related health problems](#) system can influence several of the social determinants of health and therefore has an important place in a whole system multifactorial approach to improving health and reducing inequality in health in the Liverpool City Region population.

Source Material

[***Spatial Planning for Health: an evidence resource for planning and designing healthier places***](#)

[***The Marmot Review - implications for spatial planning***](#)

Strengthening the links between planning and health in England

BMJ 2020;369:m795 | doi: 10.1136/bmj.m795

How can urban planning contribute to building health equity?

BMJ April 16, 2020 Sharon Z. Roerty, MCRP/AICP, Robert Wood Johnson Foundation, USA

[***NICE Physical activity and the environment***](#)



2. Strategic overview

of health, wellbeing and health inequalities and key determinants of health across the Liverpool City Region



The health and wellbeing of the population living in the Liverpool City Region can be described by looking at statistics that show how long people live for, for how long in good health and how common various ailments amongst other indicators. Comparing these statistics to the national data gives a sense of how good, or bad, the health of people in the city region actually is. There is also data available to show how common some factors are that determine the health of the population. These include how many people are smoking, undertaking exercise, having a healthy diet and moderate alcohol intake.

Of greater impact, and more significance in the longer-term health of the population, are wider determinants of health. Over the course of a lifetime, factors such as access to good education, training opportunities, warm housing, good employment, access to green space, clean air and freedom from systemic discrimination have the more significant effect on the health and wellbeing of the population.

An additional factor in this decade is the impact of the Covid pandemic. Both the illness itself and the effect of the measures that were taken to reduce the spread of the virus had a

profound effect on population health in the City Region. The impact is likely to be felt for the remainder of the decade.

Health Across the City Region

Life expectancy at birth reflects the overall mortality level of a population. It summarizes the mortality pattern that prevails across all age groups - children and adolescents, adults and the elderly. Life expectancy for females in 2018/20 ranges across the Liverpool City Region from 79.8 years in Knowsley to 82.4 in Sefton. The range for males in 2018/20 is similar going from 76.1 years in Liverpool to 78.0 years in Sefton. Nowhere in the city region is life expectancy as good as the England rate at 83.1 years for females and 79.4 years for males. It is also worth noting that the best life expectancy rates in the country for the same time period are 87.9 years for females and 84.7 years for males.

Healthy life expectancy at birth is an estimate of the average number of years babies born this year would live in a state of 'good' general health if mortality levels at each age, and the level of good health at each age, remain constant in the future. The range for females in the city region is from 57.5 years in Halton to 64.2

years in Sefton in 2017/19. For males it is from 58.3 years in St Helens to 63.7 years in good health in Sefton. Only the Sefton population is consistently better than the England figure for healthy life expectancy.

The percentage of adults classified as overweight or obese in the city region ranges from 63.5% in Liverpool to 78.3% in Halton. The figure in Halton is particularly high and all of the city regions are above the England rate of 62.8%. It is worth noting that the England rate of nearly two thirds of the population is considered a significant risk to the health of the population through higher risk of diabetes, cardiovascular disease and a range of cancers. Therefore, the higher levels of obesity in the city region are a significant risk to health.

Similarly, it is notable that nowhere in the city region achieves higher than the England figure for proportion of the population consuming the recommended 5 fruit and veg a day on a usual day.

The interaction between the factors that influence food consumption and therefore obesity levels are complex and best managed as part of a whole system approach to diet and obesity. Vulnerable groups, including those on a low income, children, young people,

those who are overweight or obese, and those of certain ethnicities, are less likely to achieve a healthy and balanced diet. However, the food environment, including a person's proximity to food retail outlets and the type of food available, plays an important role in promoting a healthy diet. Increased access to unhealthier food is associated with increased weight status in the general population, and increased obesity and unhealthy eating behaviours among children in low-income households. Making healthier foods more accessible and increasing provision of low-cost healthier food could be effective interventions.

Physical activity is established through research as a determinant of health. Higher levels of physical activity in a population are good for mental health and wellbeing but also for cardiovascular disease, cancers and diabetes. Across the Liverpool City Region the percentage of the population engaging in physical activity on a weekly basis ranges from 57.6% in Halton to 65.4% in Wirral. On the other hand, the highest percentage of people who are classified as inactive is also highest in Halton and lowest in Wirral. On neither measure is the physical activity level better than the England level.

Active travel (cycling, walking and use of public transport) can increase physical activity levels and improve physical and mental wellbeing. Investing in infrastructure to support walking can increase physical activity levels and improve mobility among children, adults and older adults. Provision of high-quality public transport is associated with higher levels of active travel among children.

There is consistent evidence that having access to recreational facilities, such as parks and playgrounds, is associated with reduced risk of obesity among adolescents and increase in physical activity. Evidence also suggests that improving the appearance of parks can increase usage and increase physical activity among children and older adults and, that participation in physical activity in a natural setting is associated with more improved mental health outcomes than participation in physical activity in an indoor setting.

The design of a neighbourhood can contribute to the health and well-being of the people living there. Several aspects of neighbourhood design (walkability and mixed land use) can also maximise opportunities for social engagement and active travel.

A lot of the data on population health uses mortality as a measure of health. i.e. how long do people live for and what causes them to die prematurely. However, it is also necessary to consider information on illness. Mental illness particularly does not, to a large extent, feature in mortality statistics yet it is significant as a cause of illness in many populations. The prevalence of common mental disorders is higher across all parts of the city region than for England as a whole. It also follows deprivation being higher in the more deprived parts of the population.

Mental health can be influenced by aspects of neighbourhood design that encourage social mixing and reduce isolation. The provision of mixed land use and affordable housing is strongly associated with improved safety perceptions in the neighbourhood, particularly among individuals from low-income groups. Living in good quality and affordable housing is associated with numerous positive health outcomes for the general population and those from vulnerable groups including mental wellbeing. The provision of affordable housing for the homeless has been shown to contribute to improvements in mental health status. Finally, relief of fuel poverty can contribute to better mental health.

Social Determinants of Health

It has been established that population health and especially as measured by life expectancy reflects the level of deprivation in the population.

The more affluent the population the longer people live and with more years in good health. The poorer the population the shorter the life span with more of that life lived in poor health. This is also the case across the city region and in comparing the city region with other parts of the country.

The 2019 Index of Multiple Deprivation showed that Knowsley and Liverpool are the areas with greatest deprivation and Wirral and Sefton are the least deprived within the city region.

That range shows up in the life expectancy and other indicators of population health.

It is also apparent within each of the boroughs in the city region. Life expectancy varies by around 10 years within each of the boroughs depending on what the level of deprivation is in different parts of the city.

There is a strong link between deprivation and poor health. The pattern of deprivation in the city region strongly predicts the pattern of ill health. Average earnings are below

the national average across the city region and contribute to a number of issues including food poverty, homelessness, mental health and wellbeing, and fuel poverty. Other factors tend also to be linked to the significant impact of deprivation and that includes poor housing, lack of access to green space, lower educational achievement and access to good transport that can link people to good jobs. These factors are determinants of health that show up in the form of higher levels of smoking, obesity, alcohol consumption and lower levels of physical activity.

Impact of Pandemic Covid

High levels of deprivation, driven in part by major and longstanding challenges with local economies and employment, are important reasons for poor health outcomes. COVID-19, has had its greatest effects on those with chronic health conditions and has reinforced inequalities in health.

As COVID-19 cases began to spread across the globe, it became clear that significant action was required to manage the virus. On 23rd March 2020, following a further rise in cases, the UK Government announced the first national lockdown which ended in July. The second national lockdown

took place between 5th November and 2nd December 2020, following a period of regional, tiered restrictions in September across the Liverpool City Region. The third national lockdown started on 4th January 2021; ongoing easing of restrictions commenced in March 2021. A new variant of the virus led to continued transmission and illness throughout 2021 and until the effect of wide vaccination was felt in 2022 when restrictions began to be lifted across the country.

The direct impact of the virus was felt hardest in people with existing chronic health conditions such as diabetes, obesity, cardiovascular disease and respiratory conditions, people from minority ethnic groups, older people and people living in more deprived circumstances. An additional impact was, and continues to be felt, because of the impact of the lockdown measures. Restrictions on economic activity meant that some people lost employment. Restrictions on access to education meant that many children and young people suffered an impact on learning that will continue to show as an impact on health for years to come. Restrictions on social mixing led people to be isolated particularly if they were already vulnerable to isolation.

Across the country it is recognised that the pandemic has had an effect to exacerbate inequalities in health where they already existed. This is evident along lines of deprivation and ethnicity. All six boroughs in Liverpool City Region had higher mortality from Covid 19 for men than the average for England and Wales and for women five of the six for women were higher than the national average. The relationship between all causes of mortality and deprivation in England reflects the relationship between deprivation and mortality from COVID-19. The more deprived the area, the greater the mortality rate from COVID-19.



3. Review of Local Authorities



Introduction to Halton

The resident population of Halton was estimated at 129 400 people in 2019. By 2041 the number aged 65 and over is projected to have increased by 38%.

Socio economic deprivation is a major factor in determining the health of the population and Halton is a deprived borough, relative to England as a whole (27th most deprived of 326) and 3rd in the Liverpool City Region, behind Knowsley and Liverpool.

Halton's ranking has remained the same since the previous Index of Multiple Deprivation in 2010 which ranked the Borough as the 27th most deprived borough nationally signalling that Halton is performing poorly in terms of overall deprivation. Halton has ten areas within the top 3% most deprived in England and almost half of the population live in the top 20% most deprived areas in England. Nearly one in five children, approximately 4,850, in Halton live in relative low-income households.

Population ethnicity data is from the last full census in 2011 but in reality, it is likely to have changed since then. The more recent 2020/21 Department for Education School Survey found that 8% of the population were not of

White British ethnicity. This is low in comparison to the Northwest (26%) and England (34.9%).

Health in general

The health of people in Halton is generally worse than the England average.

Life expectancy for men is 77.4 and for women is 81.4 years. This is lower than the England average indicating a population that is not in as good health as the national population in general. There is also evidence of inequality in health within the borough; life expectancy is 10.8 years lower for men and 8.8 years lower for women in the most deprived areas of Halton than in the least deprived areas.

The male healthy life expectancy at birth for Halton (the average number of years someone would expect to live in good health), in 2017-19 is 59.1 and is lower than the England average. There is a gap of 18 years between male life expectancy and healthy life expectancy in Halton meaning an estimated 18 years will be spent in 'not good' health. The female healthy life expectancy at birth is 57.5 compared to the England average of 63.5 years. Females in Halton are estimated to spend about 24 years of their life in

'not good' health. (PHOF)

Child Health

In 2018-2020 there were 2.9 infant deaths per 1,000 live births in Halton, which was better than the England rate (3.9 per 1,000). This suggests that the maternal population health in Halton is better than the national picture. (PHOF).

Data from the Local Authority Health Profiles for 2019 show that 32% of reception year children and 40% of Year 6 children were overweight (including obese) in Halton and both are higher than the national rates. About 27% of five-year-olds in Halton 2018/19 had visibly obvious dental decay compared to about 23% for the country on average.

The rate for alcohol-specific hospital admissions among those under 18 is 100 per 100 000, worse than the average for England. This represents 37 admissions per year.

In 2019, Halton had a higher-than-average rate of under 18 conceptions at 24.8 per 1,000 women aged 15-17 years in England. The rate for alcohol-specific hospital admissions among those under 18 is 59 per 100 000 population, worse than the average for England. This represents 17 admissions

per year. Levels of breastfeeding and smoking in pregnancy are worse than the England average.

Adult Health

Overall, cancer is the leading cause of mortality with 27% of all deaths in Halton. Circulatory disease causes 20% of deaths and respiratory disease accounted for 13.0% of deaths in 2020. In terms of what makes people ill in Halton then mental and behavioural disorders are much more common although cardiovascular problems and cancers are second and third most common.

Air pollution is linked to a wide range of health problems, including lung disease, stroke, and cancer. The health burden from air pollution is spread across local authorities in Liverpool City Region. Research shows that young families and poorer households tend to be disproportionately represented in areas with the highest concentrations of pollution in Britain. People living within the poorest communities in the city region are more likely to be exposed to higher levels of air pollution and would benefit the most from improvement in air quality.

The rate for alcohol-related harm hospital admissions is 863 per 100 000, worse than the average for England. This represents 1,076 admissions per year.

Estimated levels of excess weight in adults and of the adult population that is physically active are worse than the England average and poorest in the Liverpool City Region. Approximately 78% of the Halton population were classified as overweight or obese in 2019/20. Approximately 45% of the Halton population consume five fruit and veg on a usual day compared to an estimated 55% for the England population in 2019/20.

In terms of physical activity about 58% of people in Halton are active for 150+ minutes per week, lower than the England average of 66.4% while 33% are inactive (less than 30 minutes activity per week). This is higher than the England average of 23% (2018/19). Both figures are the poorest for health in the Liverpool City Region i.e. lowest proportion of the population physically active and highest proportion of the population physically inactive.

Smoking prevalence in adults in 2019 was estimated at 15% which is worse than the estimate for the England population.

The estimate prevalence of common mental disorders in adults in Halton was, in 2017, 19% and this was higher than the national population estimate. Loneliness is a factor in mental wellbeing. People who are lonely are more likely to later experience social anxiety, paranoia and depression. About 29% of the adult population in Halton say that they feel lonely, higher than the national estimate of 22% and highest in the Liverpool City Region.

Older People

Approximately 19% of the population of Halton was estimated to be aged over 65 in 2020 and this is the same as the national percentage. Halton's over 65 population has increased by a greater percentage since 2002; 3% compared to 1.7% nationally. The largest percentage growth has been in the most elderly groups and this pattern is set to continue. It is predicted that the older population will continue to grow by 38% by 2041, with growth in Halton continuing to be greater than the Northwest and England rates. Approximately 18% of older people in Halton were living in poverty in 2019 compared to approximately 14% in England.

Life expectancy at age 65 is a measure of the average number of years a person of aged 65 will live based on the current age specific death rates. In Halton, men aged 65 can be expected to live for just over a further 17 years and women for a further 20 years. This compares to just under 19 additional years for men in England on average and 21 years for women and shows that health for older people in Halton is not as good as that for older people in the country as a whole.

The estimated prevalence of common mental disorders in people aged 65 and over in Halton was 12% in 2017 which was higher than the national estimate at that time. Almost 34% of the Halton population aged 65 and over was living alone in 2011.

Falls are a large cause of emergency hospital admissions for older people. Most falls do not cause sufficient injury to receive medical attention but in those that do, fractures are the most common serious injury resulting from falls in older persons. Specifically, fractures of the hip, wrist, arm, and pelvis. In 2020/21, Halton had 2813 emergency hospitals admissions due to falls in older people per 100 000 population. This figure is higher than the national figure.

Source Material

Public Health Outcomes Framework

Local Authority Health Profiles

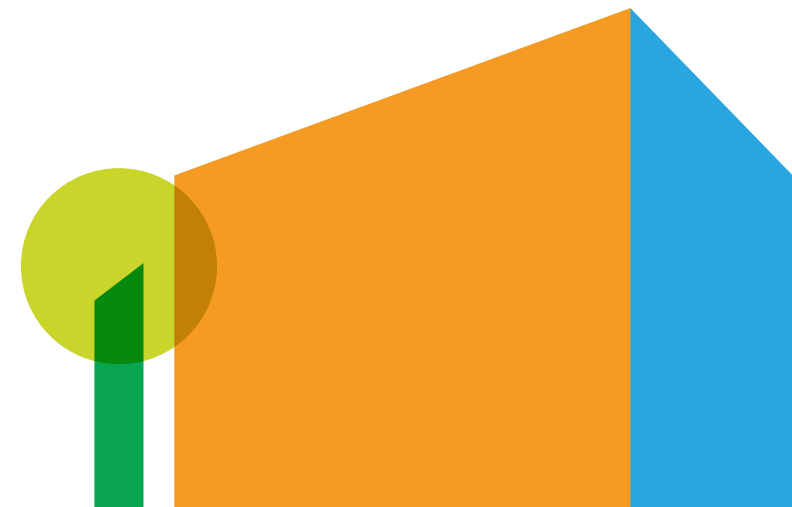
Halton JSNA

Public Health Evidence and Intelligence

JSNA

Halton Local Plan

The health and economic impacts of toxic air in Liverpool City Region



Introduction to Knowsley

Knowsley has a population of 149,571 people, and projections show that Knowsley's overall population will continue to grow. Knowsley is less ethnically diverse than England.

Socio economic deprivation is a major factor in determining the health of the population and Knowsley is one of the 20% most deprived districts/unitary authorities in England and about 25% (7,460) children live in low-income families.

Health in general

The health of people in Knowsley is generally worse than the England average.

Life expectancy for men is 76.3 and for women is 79.8 years. This is lower than the England average indicating a population that is not in as good health as the national population in general. There is also evidence of inequality in health within the borough. In the most deprived areas of Knowsley life expectancy is 11.4 years lower for men and 12.6 years lower for women than in the least deprived areas.

The male healthy life expectancy at birth for Knowsley (the average

number of years someone would expect to live in good health), in 2017-19 is 60.7 and is lower than the England average. There is a gap of 16 years between male life expectancy and healthy life expectancy in Knowsley meaning an estimated 16 years will be spent in 'not good' health. The female healthy life expectancy at birth is 59.0 compared to the England average of 63.5 years. Females in Knowsley are estimated to spend about 21 years of their life in 'not good' health. (PHOF)

Child Health

Infant mortality, which is measured as the number of infants who die in the first year of life for every 1000 live births, is a useful indicator of population health. In Knowsley the infant mortality rate is 4.68 per 1000 live births and this is higher than the national rate at 3.90/1000. This shows that the health of the population is not good in comparison to the national average.

Data from the Local Authority Health Profiles for 2019 show that 31% of reception year children and 42% of Year 6 children were overweight (including obese) in Knowsley and both are higher than the national rates. About 35% of five-year-olds

in Knowsley in 2018/19 had visibly obvious dental decay compared to about 23% for the country on average.

In 2019, Knowsley had a higher-than-average rate of under 18 conceptions at 23.5 per 1,000 women aged 15-17 years in England. The rate for alcohol-specific hospital admissions among those under 18 is 45 per 100 000 population, worse than the average for England. This amounts to 15 admissions per year. Levels of GCSE attainment (average attainment 8 score), breastfeeding and smoking in pregnancy are also worse than the England average.

Adult Health

The main illnesses that lead to early death under 75 in Knowsley are:

- Cancer
- Cardiovascular disease
- Respiratory disease.

Three factors are directly linked to premature mortality: obesity, alcohol use and smoking.

Air pollution is linked to a wide range of health problems, including lung disease, stroke, and cancer. The health burden from air pollution is spread across local authorities in Liverpool City Region. Research shows that

young families and poorer households tend to be disproportionately represented in areas with the highest concentrations of pollution in Britain. People living within the poorest communities in the city region are more likely to be exposed to higher levels of air pollution and would benefit the most from improvement in air quality.

In adults, 2 in 3 residents were classed as either overweight or obese in 2019/20. There are potential links between the high frequency of falls in Knowsley and the high levels of obesity and inactivity amongst older adults, as healthy eating and exercising regularly can help to prevent falls. Approximately 44% of the Knowsley population consume five fruit and veg on a usual day compared to an estimated 55% for the England population in 2019/20.

Knowsley had the 13th highest rate of alcohol related hospital admissions during 2019/20 and

the mortality rate from alcohol has risen by 3.2% in the last 9 years. In 2020, the proportion of people in alcohol treatment in Knowsley who had successfully completed treatment and did not return within 6 months was 32.9%. This is significantly lower than North West (41.1%) but similar to

England (35.3%).

The GP Patient survey in 2020 estimated that there are 19,600 adults who are likely to be current smokers across Knowsley. The current smoker prevalence (16.6%) is significantly above the England average of (14.3%) and the North West average of (15.1%).

Lung Cancer incidence, which is directly related to smoking prevalence, is a particular concern in Knowsley. The incidence rate in 2017-19 (133.5 per 100,000 population) was significantly higher than England (75.8).

However, progress has been made in reducing the prevalence of smoking. The current mortality rate from smoking has fallen between 2013-15 and 2017-19. The number of women continuing to smoke during pregnancy is an indication of behaviour that is a factor in infant and maternal health. Although this rate has reduced significantly in Knowsley it still remains higher in comparison to the England and Northwest average.

Estimated prevalence of common mental disorders 16 and over in 2017 is 21% compared to 18.0% for NW and 16.9% for England. Loneliness is a factor in mental wellbeing. People who are lonely are more likely to later

experience social anxiety, paranoia and depression. About 23% of the adult population in Knowsley say that they feel lonely, higher than the national estimate of 22%.

Older People

In 2020, there were over 36 000 people living in Knowsley who were aged over 60 years, which represents a 14% rise since 2001. Just under 30% of older people in Knowsley were living in poverty in 2019 compared to approximately 14% in England. Indicators of health in older people shows that the pattern of poor health in Knowsley continues into older age.

Life expectancy at age 65 is a measure of the average number of years a person of aged 65 will live based on the current age specific death rates. In Knowsley, men aged 65 can be expected to live for just over a further 17 years and women for a further 19 years. This compares to just under 19 additional years for men in England on average and 21 years for women and shows that health for older people in Knowsley is not as good as that for older people in the country as a whole.

It is estimated that in 2017 13.2% of the Knowsley population aged 65 & over experienced a common mental disorder compared to 10.9% in NW and 10.2% in England. Almost 35% of the Knowsley population aged 65 and over were living alone in 2011.

Falls are the largest cause of emergency hospital admissions for older people. Most falls do not cause sufficient injury to receive medical attention but in those that do, fractures are the most common serious injury resulting from falls in older persons. Specifically, fractures of the hip, wrist, arm, and pelvis. In 2020/21 Knowsley had the highest rate of emergency hospital admissions due to falls in people aged 65 and over in the country. The rate of hip fractures in older people (aged 65+) is worse than the England average.

Source Material

Public Health Outcomes Framework

Local Authority Health Profiles

Knowsley Public Health Statistics

Knowsley Local Plan

The health and economic impacts of toxic air in Liverpool City Region.
<http://blf.org.uk/policy>



Introduction to Liverpool

Liverpool is home to 500,474 residents and the average age in the city is 37.6 years. Population projections suggest the number of residents living in the city will increase by a further **33,400** over the next decade. The biggest change in population in Liverpool will be in those aged 60 and over. It is estimated that the number of people in this age group will increase by 16.8% - the equivalent of an additional 16,800 people.

There is a strong link between deprivation and poor health. In 2019, Liverpool was the 3rd most deprived local authority in the country. About a quarter of children in the city live in low-income families.

According to the 2011 Census some 15% of residents class themselves as part of an ethnic minority group, equating to almost 75,000 residents, while 31,500 Liverpool residents report their main language is not English. Over a third of the Liverpool population have at least one illness and about one in seven people have several illnesses including mental health problems.

Health in general

The health of people in Liverpool is generally worse than the England average.

Life expectancy for men is 76.1 and for women is 79.9 years. This is lower than the England average indicating a population that is not in as good health as the national population in general. There is also inequality in health within the city's population. Life expectancy is 11.1 years lower for men and 8.9 years lower for women in the most deprived areas of Liverpool compared to the least deprived areas.

The female healthy life expectancy at birth (the average number of years someone would expect to live in good health), is 57.7 compared to the England average of 63.5 years. There is a gap of 22 years between female life expectancy and healthy life expectancy in Liverpool meaning an estimated 22 years will be spent in 'not good' health. (PHOF) The male healthy life expectancy at birth for Liverpool, in 2017-19, is 59.5 and is lower than the England average. Males in Liverpool are estimated to spend about 17 years of their life in 'not good' health.

Child Health

In 2017-2019 there were 5.4 infant deaths per 1,000 live births, which was higher than the England rate (3.9 per 1,000). This statistic, along with the data on life expectancy above, shows that the health of the Liverpool population is not good compared to the national population.

That generally poor health is also evident in more specific conditions such as obesity. Some 4 out of 10 Liverpool children in School Year 6 are overweight or obese which is significantly higher than the England rate. Almost 37% of 5-year-olds have one or more decayed, missing or filled teeth compared to 23% nationally.

In 2018, Liverpool's under 18 years conception rate was 26 conceptions per 1,000 women aged 15-17 years which was significantly higher than the 17 per 1,000 reported nationally. The rate for alcohol-specific hospital admissions among those under 18 is worse than the average for England at about 48 admissions per year. Levels of breastfeeding and smoking in pregnancy are also worse than the England average.

Adult Health

There have been significant reductions in Liverpool's mortality rate, the portion of the population that dies over a year compared to the whole population, since the turn of the millennium, including:

- a 27% decrease in rate of preventable deaths;
- a 25% reduction in the number of preventable cancer deaths, and
- a 54% decline in the number of preventable CVD deaths,

Despite these improvements in the mortality rates, life expectancy in the city has remained level in recent years rather than improving as was previously the case.

Around 5,445 Liverpool residents died in 2020, with cancer, cardiovascular disease, Covid-19 and respiratory disease being the biggest killers. Some 2,100 people died prematurely (which is defined as being aged under 75 years), so nearly 4 out of 10 of residents died early. Premature deaths from causes considered preventable are 60% higher compared to England.

Air pollution is linked to a wide range of health problems, including lung disease, stroke, and cancer. The health burden from air pollution is spread

across local authorities in Liverpool City Region. Research shows that young families and poorer households tend to be disproportionately represented in areas with the highest concentrations of pollution in Britain. People living within the poorest communities in the city region are more likely to be exposed to higher levels of air pollution and would benefit the most from improvement in air quality.

In 2020 approximately 60,400 people have been diagnosed with depression.

Data on the immediate causes of the high mortality rates also reflect the generally worse than national average picture for health in Liverpool:

- 63.5% Liverpool adults were classified as either overweight or obese, which is in line with the national average (62.8%). However, around 26.8% of adults (aged 19+) are physically inactive and that is significantly higher than England (22.9%).

Estimated levels of smoking prevalence are better than the England average. Smoking prevalence in Liverpool has reduced from 22% in 2011 to 14% in 2019, which is like the national prevalence. However, hospital admissions for alcohol-specific

conditions in the city are more than two times the national average, and Liverpool's premature mortality rate for liver disease is 1.5 times higher than the national rate. Drug misuse is a significant cause of premature mortality in the UK and the Liverpool rate is more than twice the national rate. Around 48 people die from drug misuse each year in the city.

The estimate prevalence of common mental disorders in adults in Liverpool was, in 2017, 22% and this was higher than the national population estimate. Loneliness is a factor in mental wellbeing. About 26% of the adult population in Liverpool say that they feel lonely, higher than the national estimate of 22%.

Older People

In 2020, there were over 100,100 people living in Liverpool who were aged over 60 years, which represents a 14% rise since 2001. Approximately 30% of older people in Liverpool were living in poverty in 2019 compared to approximately 14% in England. Health related quality of life among older people in Liverpool is the fourth lowest level in the country.

Life expectancy at age 65 is a measure of the average number of

years a person of aged 65 will live based on the current age specific death rates. In Liverpool, men aged 65 can be expected to live for just under a further 17 years and women for a further 19 years. This compares to just under 19 additional years for men in England on average and 21 years for women and shows that health for older people in Liverpool is not as good as that for older people in the country as a whole.

The estimated prevalence of common mental disorders in people aged 65 and over in Liverpool was 13% in 2017 which was higher than the national estimate at that time. Loneliness is a factor in mental wellbeing. People who are lonely are more likely to later experience social anxiety, paranoia and depression. Almost 36% of the Liverpool population aged 65 and over was living alone in 2011.

Falls are the largest cause of emergency hospital admissions for older people. Most falls do not cause sufficient injury to receive medical attention but in those that do, fractures are the most common serious injury resulting from falls in older persons. Specifically, fractures of the hip, wrist, arm, and pelvis. In 2019/20, Liverpool had the highest rate in the country for falls injuries

among older people and 3234 emergency hospital admissions in people aged 65 and over per 100 000 population.

[Source Material](#)

Public Health Outcomes Framework

<https://fingertips.phe.org.uk/profile/public-health-outcomes-framework>

[Local Authority Health Profiles](#)

Liverpool JSNA

[JSNA](#)

Liverpool Public Health report

Public Health Annual Report (2021)

[Liverpool Local Plan](#)

[The health and economic impacts of toxic air in Liverpool City Region](#)



Introduction to Sefton

Sefton has a population estimated at approximately 275,899 in 2019. Approximately one quarter of the population is 65 years old or over and one in five aged under 18. The borough has an ageing population and the number of residents aged 65+ in 2015 is greater than those people in Sefton under 20. These trends are projected to continue over the next 25 years and by 2030 it is estimated that there will be over 80,000 Sefton residents aged 65 or more.

Sefton as a whole is in the most deprived fifth of English Local Authorities. Parts of the borough, particularly South Sefton, are ranked as in the most deprived areas of the country. Yet other parts of the borough, particularly in the middle and north, are some of the least deprived areas. About 17.1% (7,725) of children live in low-income families.

Sefton has a low proportion of residents from minority ethnic groups, with 95% of the population being White British, higher than rates seen across Liverpool City Region and the North West.

Health in general

The health of people in Sefton is varied compared with the England average. Life expectancy for both men and women is lower than the England average.

Life expectancy for men is 78.0 and for women is 82.4 years. This is lower than the England average indicating a population that is not in as good health as the national population in general. Inequality in health within the borough is evident in the data that shows life expectancy is 11.8 years lower for men and 11.5 years lower for women in the most deprived areas of Sefton compared to the least deprived areas.

Life expectancy at birth has remained stable for males and increased slightly for females in Sefton. Life expectancy at birth in Sefton in 2018-20 is 82.4 years for females and 77.9 years for males. Sefton male residents have a worse life expectancy than that seen nationally, yet it is better than the expectancy seen across Merseyside (and similar to that seen regionally). Females have a worse life expectancy than that nationally but are better than both the Northwest and Merseyside.

The male healthy life expectancy at birth for Sefton (the average number

of years someone would expect to live in good health), in 2017-19 is 63.7 and is slightly better than the England average. There is a gap of 14 years between male life expectancy and healthy life expectancy in Sefton meaning an estimated 14 years will be spent in 'not good' health. The female healthy life expectancy at birth is 64.2 compared to the England average of 63.5 years. Females in Sefton are estimated to spend about 18 years of their life in 'not good' health. (PHOF)

Child Health

In 2018-2020 there were 5.2 infant deaths per 1,000 live births, which was higher than the England rate (4.3 per 1,000). This statistic, along with the data on life expectancy above, shows that the health of the Sefton population is not good compared to the national population.

Data from the Local Authority Health Profiles for 2019 show that 27% of reception year children and 38% of Year 6 children were overweight (including obese), both significantly higher than the national rates.

About 30% of five-year-olds in Sefton 2018/19 had visibly obvious dental decay compared to about 23% for the country on average.

The rate for alcohol-specific hospital admissions among those under 18 is 53 per 100 000 population, worse than the average for England. This represents 28 admissions per year.

In 2019-20, Sefton's under 18 years conception rate was 18 conceptions per 1,000 women aged 15-17 years which was worse than the 16 per 1,000 reported nationally. Levels of GCSE attainment (average attainment 8 score), breastfeeding and smoking in pregnancy are worse than the England average.

Adult Health

Overall, cancer is the leading cause of mortality followed by circulatory and respiratory diseases in Sefton.

Air pollution is linked to a wide range of health problems, including lung disease, stroke, and cancer. The health burden from air pollution is spread across local authorities in Liverpool City Region. Research shows that young families and poorer households tend to be disproportionately represented in areas with the highest concentrations of pollution in Britain. People living within the poorest communities in the city region are more likely to be exposed to higher levels of air pollution and would

benefit the most from improvement in air quality.

Data on the immediate causes of the high mortality rates also reflect the generally worse than national average picture for health in Sefton. Data from the Local Authority Health Profiles for 2019 show that approximately 67% of adults in Sefton were classified as overweight or obese in 2019/20, higher than the 63% seen in England. Approximately 52% of the Sefton population consume five fruit and veg on a usual day compared to an estimated 55% for the England population in 2019/20.

In terms of physical activity about 61% of people in Sefton are active for 150+ minutes per week, lower than the England average of 66.4% while 27% are inactive (less than 30 minutes activity per week). This is higher than the England average of 23% (2018/19).

However, estimated levels of smoking prevalence in adults are better than the England average. The rate for alcohol-related harm hospital admissions is 912 per 100,000 population, worse than the average for England. This represents 2,494 admissions per year.

The estimated prevalence of common mental disorders in adults in 2017 was about 17% in Sefton which is similar to the national average. It is also notable that the 16% of people who, in 2019/20, stated that they feel lonely is lower than elsewhere in the city region and much lower than the national figure of 22%. Loneliness is a factor in mental wellbeing. People who are lonely are more likely to later experience social anxiety, paranoia and depression.

Older People

Currently more than one in every five of Sefton's residents is over 65; this is predicted to be close to one in three by 2037. This means Sefton has one of the oldest populations in the Northwest. This brings specific challenges for housing, health care and other services, and for the local workforce. Approximately 17% of older people in Sefton were living in poverty in 2019 compared to approximately 14% in England.

based on the current age specific death rates. In Sefton, men aged 65 can be expected to live for just over a further 18 years and women for a further 21 years. This compares to just under 19 additional years for men in England on average and 21 years

for women and shows that health for older people in Sefton is not as good as that for older people in the country as a whole.

The estimated prevalence of common mental disorders in people aged 65 and over in Sefton was 11% in 2017 which was about the same as the national estimate at that time. Of the Sefton population aged 65 and over, 32% were living alone in 2011.

Falls are a large cause of emergency hospital admissions for older people. Most falls do not cause sufficient injury to receive medical attention but in those that do, fractures are the most common serious injury resulting from falls in older persons. Specifically, fractures of the hip, wrist, arm, and pelvis. In 2020/21, Sefton had 2739 emergency hospital admissions due to falls in older people per 100 000 population. While this was lowest in the city region it was still higher than the national figure.

[Source Material](#)

[Public Health Outcomes Framework](#)

[Local Authority Health Profiles](#)

Sefton JSNA

[JSNA](#)

[Sefton Public Health Annual report](#)

[Public Health Annual Report \(2021/2022\)](#)

[Sefton Local Plan](#)

[The health and economic impacts of toxic air in Liverpool City Region](#)



Introduction to St. Helens

The resident population of St. Helens Borough, that totalled 179,331 in 2017, is expected to grow steadily, albeit at a slower rate than for the North West and for England. The borough has an aging population with a higher proportion of people aged 65 years and over, and proportionally fewer people of working age between 16 to 64 years old than England as a whole.

Socioeconomic deprivation is a major factor in determining the health of the population and St Helens is now ranked as the 26th most deprived local authority in England out of 317. Nearly a quarter of St Helens population live in neighbourhoods within the borough that fall within the 10% most deprived neighbourhoods nationally. It is estimated that 30% of children (12,038 in total) live in poverty. This was the 19th highest out of 39 local authority districts in 2018.

The Borough is ethnically less diverse than many other areas, with 96.6% of the population identifying themselves as white, compared to 79.8% nationally and 87.1% in the Northwest.

Health in general

The health of people in St. Helens is varied compared with the England average. Life expectancy for men is 77.5 years and for women is 81.0 years. This is lower than the England average indicating a population that is not in as good health as the national population in general. There is also evidence of inequality in health within the borough; life expectancy is 12.4 years lower for men and 8.6 years lower for women in the most deprived areas of St. Helens than in the least deprived areas.

The male healthy life expectancy at birth for St Helens (the average number of years someone would expect to live in good health), in 2017-19 is 58.3 and is lower than the England average. There is a gap of 19 years between male life expectancy and healthy life expectancy in St Helens meaning an estimated 19 years will be spent in 'not good' health. The female healthy life expectancy at birth is 58.4 compared to the England average of 63.5 years. Females in St Helens are estimated to spend about 23 years of their life in 'not good' health. (PHOF)

Child Health

In 2018-2020 there were 3.2 infant deaths per 1,000 live births in St Helens, which was slightly better than the England rate (3.9 per 1,000). (PHOF).

Data from the Local Authority Health Profiles for 2019 show that 28% of reception year children and 39% of Year 6 children were overweight (including obese) and both are higher than the national rates.

The rate for alcohol-specific hospital admissions among those under 18 is 100 per 100 000, worse than the average for England. This represents 37 admissions per year.

In March 2019, St Helens had the 4th highest rolling annual rate of under 18 conceptions at 34.6 per 1,000 women aged 15-17 years in England. Levels of GCSE attainment (average attainment 8 score), breastfeeding and smoking in pregnancy are worse than the England average. (LA Health Profiles 2019).

Adult Health

Premature mortality (aged under 75 years) fell in 2018, after a small rise in previous years. The 2019 male rate in St Helens is at the level seen in 2013, while the female 2019 rate is similar to the same rate in 2015. Rates are above the national average but similar to the Northwest average

Overall, cancer is the leading cause of mortality for under 75s with 26% of all deaths. Circulatory disease causes a quarter of deaths (24%). For males, there has been an increase in both circulatory disease and cancer since 2018 and for males, deaths from circulatory diseases have increased and are now the main cause of death. Circulatory disease has also increased for females but cancer remains the leading cause of death for females.

For both men and women in St Helens, life expectancy correlates with deprivation, with a lower life expectancy seen in more deprived areas than the least deprived. For males, there is 10.4 years difference between the wards with the highest and lowest life expectancy. For females, there is 9.2 years difference between the wards with the highest and lowest life expectancy.

Air pollution is linked to a wide range of health problems, including lung disease, stroke, and cancer. The health burden from air pollution is spread across local authorities in Liverpool City Region. Research shows that young families and poorer households tend to be disproportionately represented in areas with the highest concentrations of pollution in Britain. People living within the poorest communities in the city region are more likely to be exposed to higher levels of air pollution and would benefit the most from improvement in air quality.

The rate for alcohol-related harm hospital admissions is 883 per 100 000 population, worse than the average for England. This represents 1,566 admissions per year. St Helens has one of the highest rates of alcohol-related hospital admissions in England.

Estimated levels of excess weight in adults and physically active adults are worse than the England average. Although the estimated percentage of adults who are overweight or obese is reducing in St Helens it still stands at 67.0% of the adult population of whom about 18,223 persons are registered by their GP as 'obese'. Approximately 48% of the St Helens population consume five fruit and veg on a usual

day compared to an estimated 55% for the England population.

In terms of physical activity about 62% of people in St Helens are active for 150+ minutes per week, lower than the England average of 66.4% while 24% are inactive (less than 30 minutes activity per week). This is higher than the England average of 23% (2018/19).

Smoking prevalence in adults in 2019 was estimated at 13% which is slightly better than the estimate for the England population.

The estimated prevalence of common mental disorders in adults in St Helens was, in 2017, 18% and this was slightly higher than the national population estimate. Loneliness is a factor in mental wellbeing. About 21% of the adult population in St Helens say that they feel lonely, and this is about the same as the national population.

From 2009-2011 to 2015-2017, the number of male suicides had increased by 112%. The number of female suicides has remained relatively consistent with the England female average. Since 2015-17, the male suicide rate in St Helens has decreased by 25%, from 32 per 100,000 males to 24, compared to an England average for males of 15.5 per 100 000.

Older People

One in five of the population of St Helens was estimated to be aged over 65 in 2020 and this is higher than the national percentage. The number of residents in St Helens who are in their 80s is expected to almost double to 12 800 in 2037, and the number of residents in their 90s is expected to almost triple to 97 003. Just under 17% of older people in St Helens were living in poverty in 2019 compared to approximately 14% in England.

Life expectancy at age 65 is a measure of the average number of years a person of aged 65 will live based on the current age specific death rates. In St Helens, men aged 65 can be expected to live for just under a further 18 years and women for a further 20 years. This compares to just under 19 additional years for men in England on average and 21 years for women and shows that health for older people in St Helens is not as good as that for older people in the country as a whole.

The estimated prevalence of common mental disorders in people aged 65 and over in St Helens was 11% in 2017 which was about the same as the national estimate at that time. Loneliness is a factor in mental wellbeing. People who are lonely are more likely to later experience social anxiety, paranoia and depression. Almost 32% of the St Helens population aged 65 and over was living alone in 2011.

Falls are a large cause of emergency hospital admissions for older people. Most falls do not cause sufficient injury to receive medical attention but in those that do, fractures are the most common serious injury resulting from falls in older persons. Specifically, fractures of the hip, wrist, arm, and pelvis. In 2020/21, St Helens had 2798 emergency hospitals admissions due to falls in older people per 100 000 population. This figure is higher than the national figure.

Source Material

[*Public Health Outcomes Framework*](#)

[*Local Authority Health Profiles*](#)

[*St Helens Public Health Report*](#)

St Helens JSNA

[*JSNA*](#)

[*St Helens Local Plan*](#)

[*The health and economic impacts of toxic air in Liverpool City Region*](#)

Introduction to Wirral

The population of Wirral is estimated to be 322,796 in 2019. The population is projected to increase by 1.6% overall by 2039 according to the Office for National Statistics, from 323,200 to 328,500. Wirral has a higher proportion of older people and a lower proportion of working age people compared to England.

Wirral is one of the 20% most deprived districts/unitary authorities in England and about 19.2% (11,190) children live in low-income families.

In 2011, 5.0% of the population of Wirral were from the Black and Minority Ethnic population.

Health in general

The health of people in Wirral is varied compared with the England average.

Life expectancy at birth in Wirral in 2018-20 is 81.6 years for females and 77.8 years for males. (PHOF). This is lower than the England average indicating a population that is not in as good health as the national population in general. There is also evidence of inequality in health within the borough; life expectancy is 10.8 years lower for men and 8.8 years lower for women in the most deprived areas of Wirral than

in the least deprived areas.

The male healthy life expectancy at birth for Wirral (the average number of years someone would expect to live in good health), in 2017-19 is 60.9, lower than the England average. There is a gap of 17 years between male life expectancy and healthy life expectancy in Wirral meaning an estimated 17 years will be spent in 'not good' health. The female healthy life expectancy at birth is 63.9 compared to the England average of 63.5 years. Females in Wirral are estimated to spend about 18 years of their life in 'not good' health. Another way of looking at this is that people in Wirral spend around three-quarters of their life in good health, but this is lower than in England.

Child Health

In 2018-2020 there were 3.5 infant deaths per 1,000 live births in Wirral, which was similar to the England rate. (PHOF). Data from the Local Authority Health Profiles for 2019 show that 28% of reception year children and 35% of Year 6 children were overweight (including obese.) Both figures are close to the national rates.

The rate for alcohol-specific hospital admissions in Wirral among those under 18 is 44 per 100 000 population, worse than the average for England. This represents 30 admissions per year. Levels of breastfeeding and smoking in pregnancy are worse than the England average.

In 2019-20, Wirral's under 18 years conception rate was 22 conceptions per 1,000 women aged 15-17 years which was worse than the 16 per 1,000 reported nationally. Levels of breastfeeding and smoking in pregnancy are worse than the England average. (LA Health Profiles 2019).

Adult Health

The largest contributors to the gap were the same for both males and females in Wirral; namely cancers, cardiovascular disease and respiratory disease.

Air pollution is linked to a wide range of health problems, including lung disease, stroke, and cancer. The health burden from air pollution is spread across local authorities in Liverpool City Region. Research shows that young families and poorer households tend to be disproportionately represented in areas with the highest concentrations of pollution in Britain.

People living within the poorest communities in the city region are more likely to be exposed to higher levels of air pollution and would benefit the most from improvement in air quality.

Overall, one in five (22%) of the population reported that their day-to-day activities were limited in some way by an illness or disability in the census, but this hides large variations by age (from just 7% in those aged <35 to 83% of those aged 85+).

Poor mental health also affects communities in Wirral differently with referrals to mental health services three times higher in areas of deprivation than more affluent areas. Prevalence of depression is much higher in Wirral than England; at 18% of adults compared to 11% nationally according to GP records. In areas of higher deprivation as many as 1 in 3 residents are recorded as having depression.

The estimate prevalence of common mental disorders in adults in Wirral was, 17% in 2017, and this was slightly higher than the national population estimate. Loneliness is a factor in mental wellbeing. People who are lonely are more likely to later experience social anxiety, paranoia and depression. About 21% of the

adult population in Wirral say that they feel lonely, and this is slightly lower than the national population.

The rate for alcohol-related harm hospital admissions is 895 per 100,000 population, worse than the average for England. This represents 2,858 admissions per year. Harmful alcohol consumption patterns match deprivation across the borough. The most deprived wards in Wirral had the highest rate of mortality that was specifically caused by alcohol.

The estimated level of smoking prevalence in adults, 10.7%, is better than the England average. Whilst Wirral's smoking prevalence is lower than national comparisons, this varies significantly between communities. These differences are also evident during pregnancy with smoking in pregnancy, and at delivery, higher in less affluent communities and breastfeeding is lower.

Estimated levels of excess weight in adults and physically active adults are worse than the England average. The proportion of adults classified as overweight or obese still stands at 69.0% of the adult population. The proportion of adults classified as either overweight or obese varies from higher in the least affluent parts of Wirral compared to lower in the most

affluent areas. Approximately 52% of the Wirral population consume five fruit and veg on a usual day compared to an estimated 55% for the England population.

In terms of physical activity about 65% of people in Wirral are active for 150+ minutes per week, about the same as the England average of 66.4% while 22% are inactive (less than 30 minutes activity per week). This is similar to the England average of 23% (2018/19).

Older People

Slightly more than one in five (22%) of the population of Wirral was estimated to be aged over 65 in 2020 and this is higher than the national percentage. Just under 17% of older people in Wirral were living in poverty in 2019 compared to approximately 14% in England.

Life expectancy at age 65 is a measure of the average number of years a person of aged 65 will live based on the current age specific death rates. In Wirral, men aged 65 can be expected to live for just under a further 18 years and women for a further 20 years. This compares to just under 19 additional years for men in England on average and 21 years for women and shows that health for

older people in Wirral is not as good as that for older people in the country as a whole.

The estimated prevalence of common mental disorders in people aged 65 and over in Wirral was 11% in 2017 which was about the same as the national estimate at that time. Almost 34% of the Wirral population aged 65 and over was living alone in 2011.

Falls are a large cause of emergency hospital admissions for older people. Most falls do not cause sufficient injury to receive medical attention but in those that do, fractures are the most common serious injury resulting from falls in older persons. Specifically, fractures of the hip, wrist, arm, and pelvis.. In 2020/21, Wirral had 2761 emergency hospitals admissions due to falls in older people per 100 000 population. This figure is higher than the national figure.

[Source Material](#)

Public Health Outcomes Framework

[Local Authority Health Profiles](#)

Wirral JSNA

[JSNA](#)

[Compendium of Statistics](#)

[Embracing Optimism: Living with Covid-19 - 2021 Public Health Annual Report](#)

[Covid-19 Mortality in Wirral](#)

[Wirral Local Plan](#)

[The health and economic impacts of toxic air in Liverpool City Region](#)





► For more information on **Spatial Planning at the Liverpool City Region Combined Authority** or the **Spatial Development Strategy**

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