HALTON JOINT STRATEGIC NEEDS ASSESSMENT (JSNA)

Understanding the drivers of healthy life expectancy

HALTON BOROUGH COUNCIL

OneHalton
Working better together

Contents

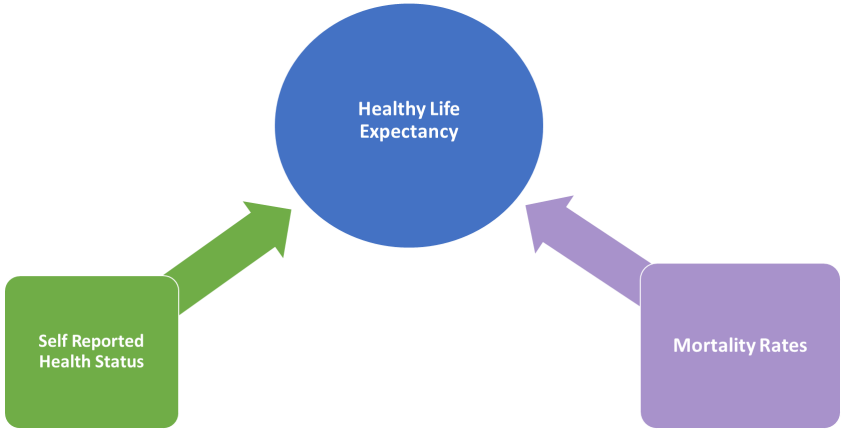
What do we mean by healthy life expectancy?

The Office for National Statistics' (ONS) measure of healthy life expectancy (HLE) can be defined as a function of mortality rates and the prevalence of self-reported good health (derived mostly from the Annual Population Survey [APS] and in part from the census).

The APS is a nationally representative survey, in which participants are asked to rate their general health on a 5-point scale from 'very bad' to 'very good'. Self-reported health is, conventionally, dichotomised so that those reporting 'very bad', 'bad', or 'fair' health are categorised as being in 'poor health' and those reporting 'good' or 'very good' health are categorised as being in 'good health'.

Figure 1 represents these two elements and this report will explore levels of both in Halton and how we compare to our Cheshire & Merseyside neighbours, regionally and

Figure 1: diagram summarising the relationship of self-reported health status, mortality rates and healthy life expectancy



What is the policy interest in healthy life expectancy?

Improving Healthy Life Expectancy (HLE) remains a priority across government and there is a need to better understand what drives it.

Ambitions around HLE are cited in several policy documents including Levelling Up The United Kingdom white paper (2022) which outlined the following 'mission':

"By 2030, the gap in Healthy Life Expectancy (HLE) between local areas where it is highest and lowest will have narrowed, and by 2035 HLE will rise by 5 years."

This ambition was most recently reiterated in January 2023, in a Secretary of State announcement on a new strategy to tackle major health conditions.[1]

A clear articulation of what drives HLE hasn't really existed to date (yet it is being asked for). To this end a national report was issued by the Office for Health Improvement and Disparities (OHID) to understand the drivers for HLE. This report uses the national report in combination with local data.[2]

Why does healthy life expectancy matter?

Most people live well into old age. So it is important that we can have happy, healthy lives no matter how long we live. Being in poor health can prevent people from having as full and active a family life, enjoying themselves, spending time with friends and working (whether paid or voluntary work) as they want.

Healthy life expectancy (HLE) is a way of measuring how much of people's lives they spend in good health. Analysis is conducted by the Office for National Statistics at local authority level. It is calculated as years of good health at both birth and age 65 for

1. https://www.gov.uk/government/consultations/major-conditions-strategy-call-for-evidence
2. https://www.gov.uk/government/publications/understanding-the-drivers-of-healthy-life-expectancy/understanding-the-drivers-of-healthy-life-expectancy-report

LIFE EXPECTANCY AND HEALTHY LIFE EXPECTANCY IN HALTON

Life expectancy across Halton has been improving but remains below the regional and national averages. It means that on average people in Halton can expect to live 2 years less than across England as a whole.

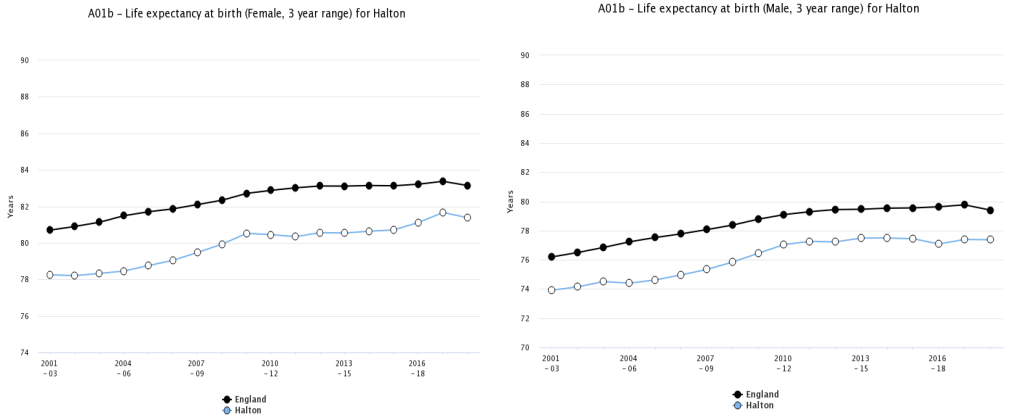
However, it is not just compared to the national average that there are differences. The gap in life expectancy across electoral wards is substantial.

Men in Halton Lea had an average life expectancy at birth (based on 2018-20 figures) of 73.1 years compared to men living in Birchfield whose average life expectancy 2018-20 was 82.7 years. The Halton average was 77.4, slightly lower than the regional average of 77.9 and lower than the national average of 79.4.

For women the average life expectancy was highest in Daresbury, Moor & Sandymoor electoral ward at 89.2 years compared to 78.1 years in Central & West Bank. The Halton average was 81.4 years, slightly lower than the regional average of 81.7 and lower than the national average of 83.1.

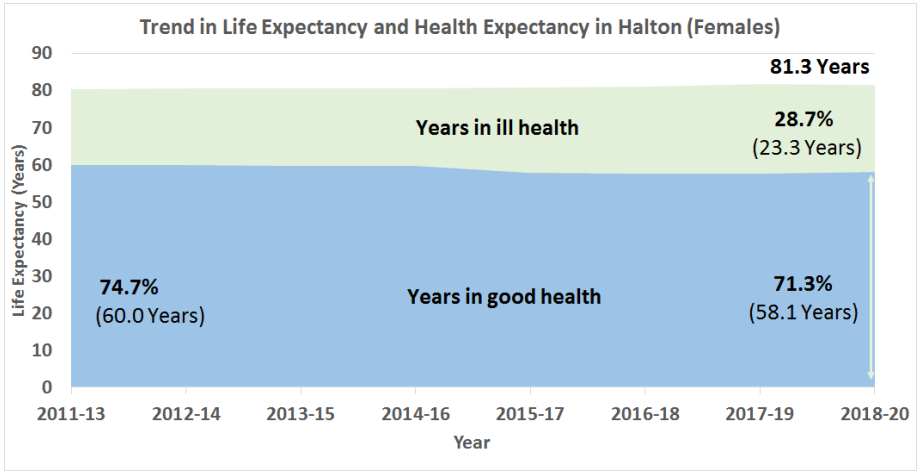
Across deprivation deciles the difference is 11.7 years for men and 9.6 for women.

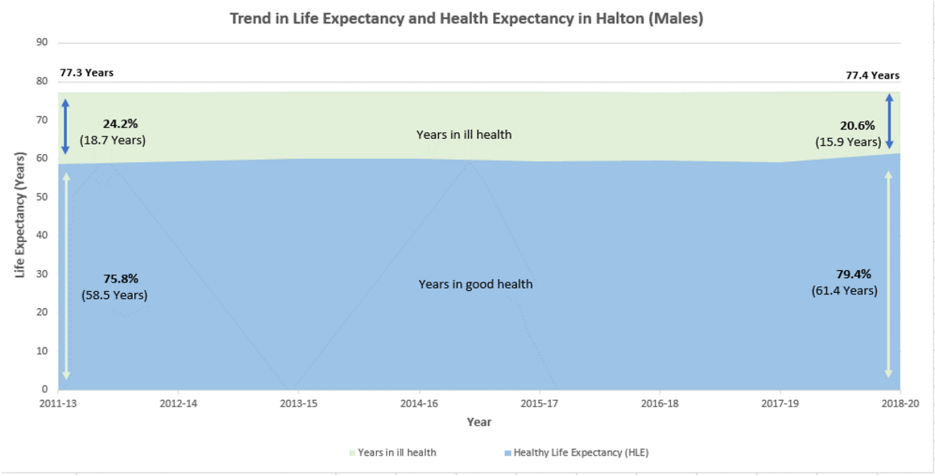
Figure 2: trends in life expectancy, Halton compared to England



For life expectancy whilst we have continued to see improvements the rate of increase has slowed in recent years. However, the extra years of life are not necessarily being spent in good health. In fact women are spending a greater proportion of their lives in poor health now compared to a decade ago whereas there has been an improvement for men. This is measured by an indicator known as healthy life expectancy.

Figure 3: trends in both life expectancy and healthy life expectancy





SELF REPORTED HEALTH

The Office for National Statistics (ONS) measure self-reported good health mostly from the Annual Population Survey (APS) and in part from the Census. The APS is a nationally representative survey, in which participants are asked to rate their general health on a 5-point scale from 'very bad' to 'very good'. Self-reported health is split in two so that those reporting 'very bad', 'bad', or 'fair' health are categorised as being in 'poor health' and those reporting 'good' or 'very good' health are categorised as being in 'good health'.

Data from the APS is available at a local authority level. The sample size is sufficient to give robust, representative results at this level. It is the reliance on APS data that is the reason why it is not possible to calculate healthy life expectancy at a ward level.

The work carried out by OHID at national level suggests self-reported health has a more significant effect on healthy life expectancy than mortality. For example, their model calculated that if a 2% improvement in mortality could be achieved healthy life expectancy would increase by just 0.1 years. However if self reported good health improved by 2% healthy life expectancy would increase by 1.3 years. This is because, by definition, healthy life expectancy is trying to measure how many years are spent in good health whereas life expectancy is concerned with how many years of life a person has.

Levels of self reported health within the APS

There are 4 measures of self-reported health within the APS. Unlike the Census, data is not available by any personal characteristics or lower geography. Whilst Halton values are worse than England they are not statistically significantly different.

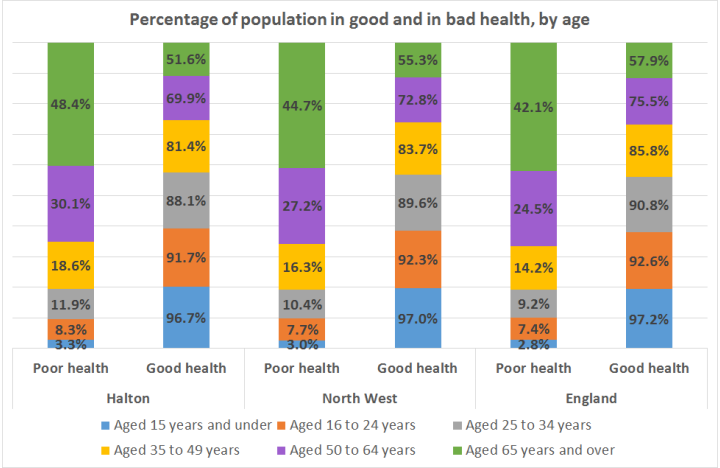
Indicator	Period	Halton			England			
		Recent Trend	Count	Value	Value	Worst	Range	Best
Self reported wellbeing: people with a low satisfaction score	2021/22	-	-	8.3%	5.0%	9.8%		
Self reported wellbeing: people with a low worthwhile score	2021/22	-	-	5.9%	4.0%	9.4%		
Self reported wellbeing: people with a low happiness score	2021/22	-	-	9.5%	8.4%	14.8%		
Self reported wellbeing: people with a high anxiety score	2021/22	-	-	26.5%	22.6%	31.7%		

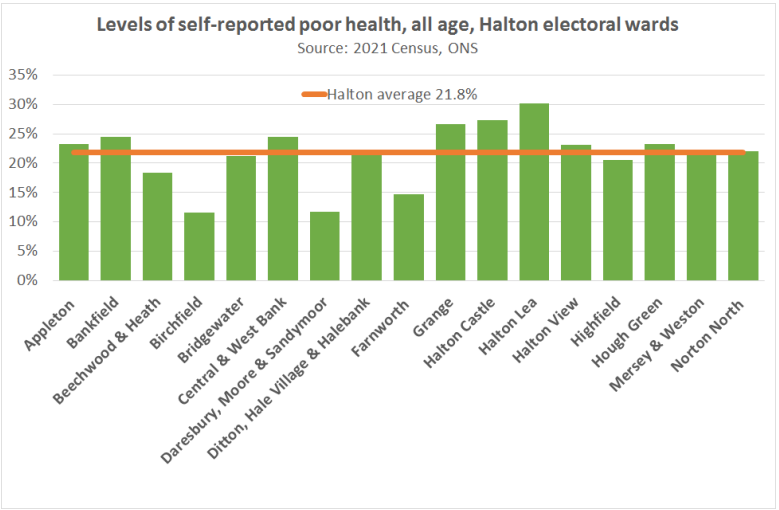
Source: ONS via OHID Fingertips profiles

Levels of self reported health within the Census

The Census reports against 3 categories: Bad & very bad, fair and good & very good. For ease of analysis bad and fair have been amalgamated into a poor health category.

It shows that whilst Halton follows a similar age profile, at every age group Halton has a higher percentage of the population reporting poor health than the regional and national averages.





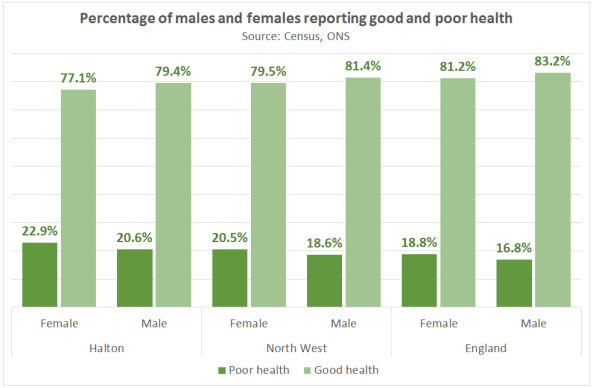
Levels of self reported poor health range from 11.6% in Birchfield to 30.1% Halton Lea, against the Halton average of 21.8%.

SELF REPORTED HEALTH: PROTECTED CHARACTERISTIC GROUPS

The 2021 Census includes a tool for the first time that enables users to create bespoke datasets from the underlying raw data. So whilst it is not as timely as the APS it does offer us more detailed insights.

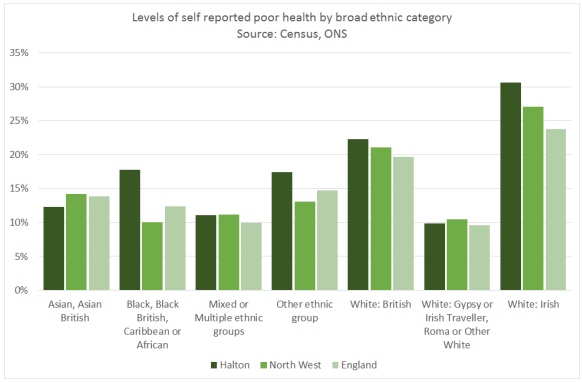
We have already seen that age is a key determining factor in levels of self reported poor and good health. The following sections will detail, where available Census data for the other 8 protected characteristic groups as well as some other key vulnerable groups. Where Census data is not available research is used.

Gender: there was a slightly higher percentage of women reporting poor health than men, 22.9% versus 20.6%. For both males and females the levels reporting poor health are higher in Halton than its comparators



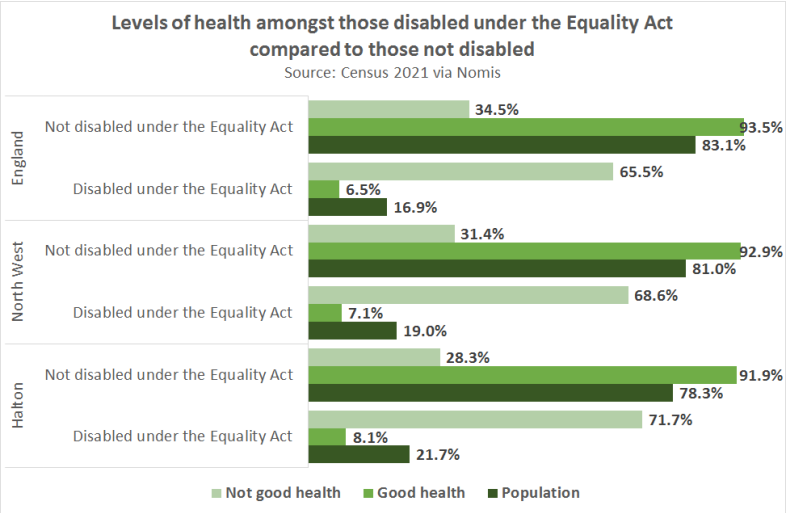
Race (ethnicity):

The proportion of the population reporting poor health is highest in the White Irish and White British groups. Of the Black, Asian and Minority Ethnic groups the level is highest amongst Black, Black British, Caribbean or African group. ONS point out this may be in part due to age differences. Nationally the average age of White Irish is 54 compared to 40 generally.



Disability: Halton has a higher proportion of its population how identify themselves as disabled using the Equality Act definition. Of these 7 out of 10 (71.1%) reported their health was poor, higher than the regional and national averages. This compares to just over 2 out of 10 (21.8%) of the population as a whole.

For both disabled and non-disabled people in Halton the proportion reporting their health is good fall with age.

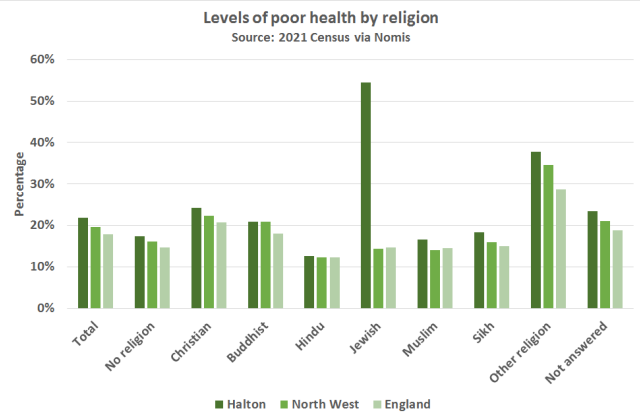


HALTON BY AGE	Not disabled		Disabled	
	Good health	Not good health	Good health	Not good health
Aged 14 years and under	99.3%	0.7%	67.2%	32.8%
Aged 15 to 24 years	98.0%	2.0%	57.2%	42.8%
Aged 25 to 34 years	95.4%	4.6%	47.5%	52.5%
Aged 35 to 44 years	94.0%	6.0%	36.4%	63.6%
Aged 45 to 54 years	91.2%	8.8%	25.5%	74.5%
Aged 55 to 64 years	87.4%	12.6%	19.4%	80.6%
Aged 65 to 74 years	80.7%	19.3%	18.1%	81.9%
Aged 75 years and over	70.5%	29.5%	14.5%	85.5%

SELF REPORTED HEALTH: PROTECTED CHARACTERISTIC GROUPS

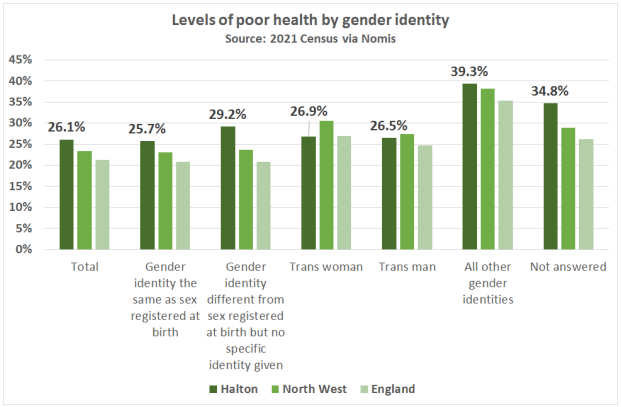
Religion: Across all religious groups Halton has a higher proportion identifying that their health is poor compared to England. The differences are marginal between Halton and the North West.

The only anomaly is those identifying themselves as Jewish in Halton amongst whom 54.5% said their health was poor. This is likely to be an artefact of small numbers.

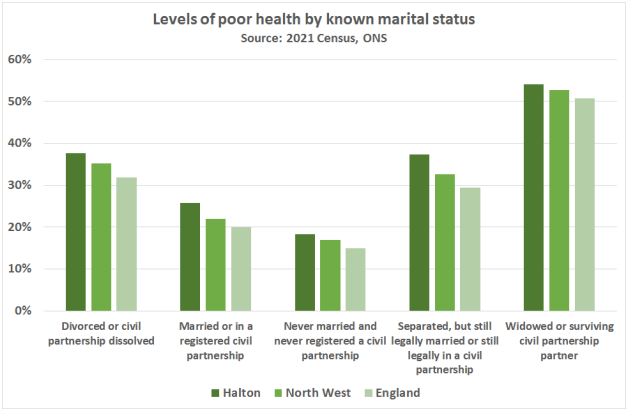


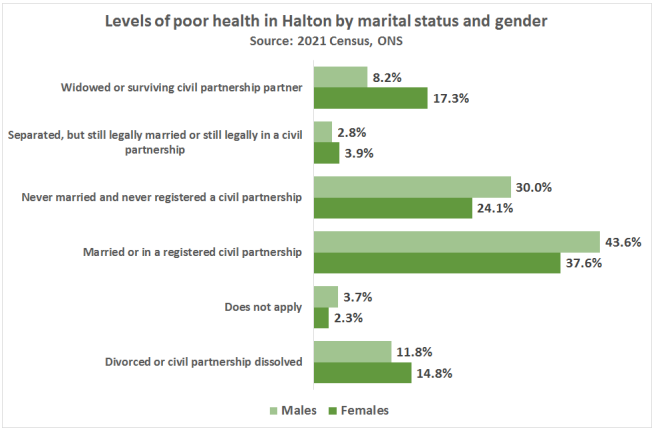
The difference between Halton and comparators was smallest for Hindu's who also had the smallest proportion identifying their health as poor.

Gender identity: Those who identify themselves as having the same gender now as at birth have lower levels of poor health. Across the different categories of gender identity in the Census, Halton has higher proportions reporting poor health than comparators (apart from trans men and women where North West averages are higher).



Marital status: Those who have never married or been in a civil partnership have the lowest levels of poor health. The patterns in Halton by marital status mirror comparators albeit higher levels of poor health are seen across all marital status categories than comparators. Over half of those widowed said their health was poor compared to less than 1 in 5 of single people.



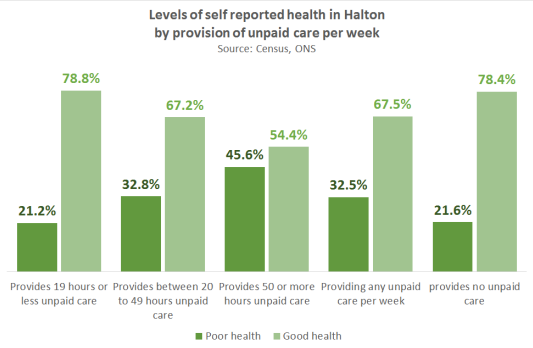


Gender does have an influence on this also. Halton analysis shows single men having higher levels of poor health than single women. Divorce and widowhood seem to result in higher levels of poor health for women than for men. For both genders levels of poor health are highest amongst those married or in civil partnerships.

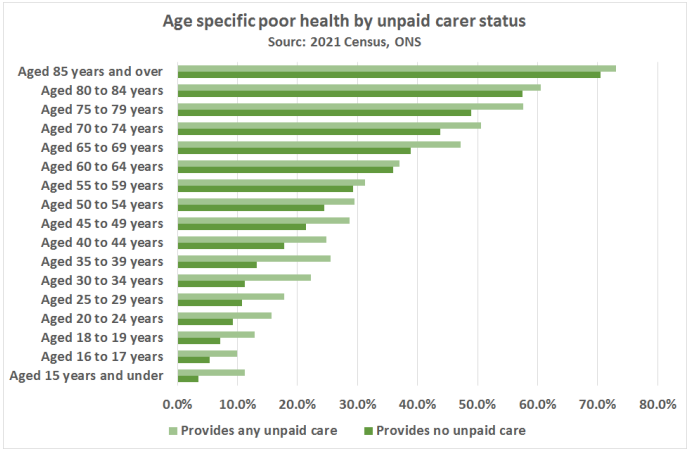
Pregnancy: there is no data in the Census on how pregnancy impacts self-reported health. Research shows around 14.2% of pregnant women report poor health. This is similar to the Halton Census data for all women of childbearing age (16-49) which was 15.8%. This would suggest pregnant women do not feel worse about their health than women generally. Other studies have showed health-related quality of life to be significantly lower in pregnant women compared to non -pregnant women. Migrant women have higher odds of poor self-reported health before, during and after pregnancy. Mental health problems in pregnancy and the postnatal period are relatively common and in pregnancy are associated with an increase in adverse outcome.

SELF REPORTED HEALTH: OTHER VULNERABLE GROUPS

Carers: Halton has a higher proportion of its population who provide unpaid care to a family member or friend on a weekly basis than in the region or nationally. Providing unpaid care can be highly stressful and research indicates carers can neglect their health in favour of the needs of the person they care for.



The NHS Long-term plan commits the NHS to identifying more carers than it currently does and ensuring they have a contingency plan should they be unable to provide care at short notice due to illness or incapacity. It is not surprising therefore than the proportion of carers reporting their health is poor is higher than for those who do not provide care. Nearly half of those providing 50 hours of more care a week report their health is poor.



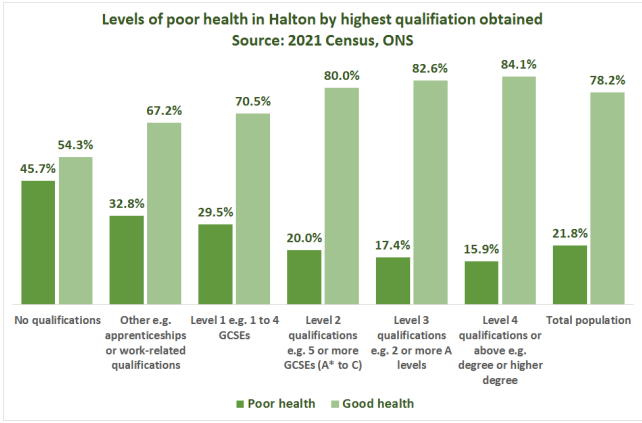
As with overall levels of poor health, for those providing unpaid care, levels of poor health increase with age. At all age groups self-reported poor health levels are higher amongst those providing any hours of unpaid care per week.

Twice as many women provide unpaid care as men (11396 versus 5674). However a higher proportion of men providing unpaid care report poor health, at 33.8% compared to 22.9% for women.

Homeless: Data from Homeless Link (national charity) in their report 'The Unhealthy State of Homelessness 2022' shows over half of people experiencing homelessness suffer from physical and mental health problems, rates much higher than the general population. 63% of participants reported long-term physical health conditions and 82% a mental health diagnosis. 56% of respondents received a diagnosis of a physical health condition after becoming homeless, whereas 72% reported their mental health diagnosis pre-dated their becoming homeless. Research data from older adults (aged 50+) who had experienced homelessness for a month of more compared to those who had not showed 30.5% of those who has not been homeless rated their health as poor compared to 41.9% who had.

Those with have no or basic education: ONS analysis of the 2014-2016 national wellbeing data showed that having lower or no basic educational qualifications appears to be associated with the poorest personal well-being. Of those with the poorest personal well-being, 24.5% reported either basic or no qualifications, which compares with 8.2% among those reporting higher well-being. Similarly, a relatively small proportion of those with the poorest personal well-being had a degree compared with those with higher well-being, 21.3% and 39.1% respectively.

This was national data. It can now be analysed within the Census data . This shows a clear progression of increasing levels of poor health with each level of qualification. Lowest levels of poor health are in those with degrees or higher level qualifications; lowest levels amongst those with no formal qualifications.

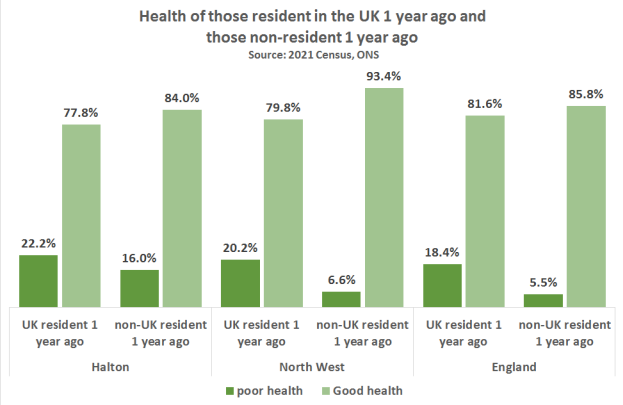


SELF REPORTED HEALTH: OTHER VULNERABLE GROUPS

Migrants and asylum seekers: Adult refugees and asylum seekers living in Western countries experience a high prevalence of mental health problems, especially post traumatic stress disorder (PTSD), depression and anxiety. There are gender differences. Asylum seekers have a higher level of self reported PTSD and depression/anxiety symptoms compared to refugees. However, residence status appears to act as a marker for post migration stressors. Compared to refugees, asylum seekers utilise GP services more often, but not mental health services.

Overall, migrants in the UK are healthier than the UK born population. People who migrate for employment, family and study reasons have better health than the UK born, while those who migrated to seek asylum have worse health outcomes. To note there may be other vulnerable groups with special health needs within the migrant population, whose outcomes will not be clearly visible when looking at averages in the data.

The Census asks if people where resident in the UK a year ago. It shows a general pattern of people who have been residing in the UK less than a year stated their health was generally better than those residing in the UK for over a year. This may be impacted by a population migrating to the UK that is generally younger and fitter than the overall population.



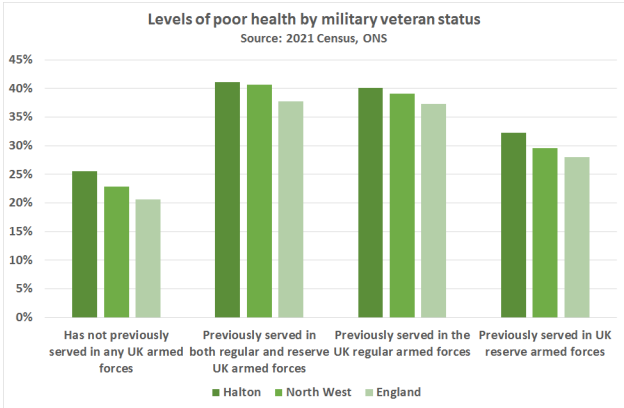
Other data in the Census that can be used to understand levels of health amongst migrant populations is national identity. Of those who identify themselves as being a UK resident for less than a year with a non-UK identity there are higher levels of poor health than those identifying as having a non-UK identity but have lived in the UK for a year or more. Whilst the Halton percentage amongst those resident for less than a year is higher than the regional and national averages the pattern is the same. Small numbers in Halton are likely affecting the analysis.

Levels of poor health amongst those identfying as having a non-UK national identity by length of UK residence

		Non-UK identity only
Halton	Living in UK for a year or more	0.3%
	Address one year ago was outside the UK	10.4%
North West	Living in UK for one year or more	0.8%
	Address one year ago was outside the UK	3.7%
England	Living in UK for a year or more	0.7%
	Address one year ago was outside the UK	3.5%

Source: 2021 Census. ONS

Military veterans: a previous Halton health needs assessment of military veterans found their health to be overall poorer than the general population. Data from the Census concurs with this. It shows levels of poor health are lower amongst those who have not served in the armed forces. Levels of poor health were highest for those who has served in the regular armed forces but were also high amongst ex- reserve forces personnel. Levels of poor health in Halton were higher than comparators.



What is the Health Index and how is it calculated?

The Health Index for England is a new measure of the health of the nation. It uses a broad definition of health, including:

- health outcomes
- health-related behaviours and personal circumstances
- wider drivers of health that relate to the places where people live

The Health Index provides a single value for health that can show how health changes over time. It can also be broken down to focus on specific topics to show the factors that influence these changes.

The overall Health Index score can be broken down into three areas of health, known as domains, which are:

- Healthy People focusing on health outcomes
- Healthy Lives focusing on health-related behaviours and personal circumstances
- Healthy Places focussing on social and environmental risk factors

Each domain contains several subdomains. These in turn contain a number of indicators. Some of these will be used later in the report to look at individual factors of significance in the OHID analysis.

Each indicator provides a measure of a particular aspect of health. All data used is publically available. As such it may not be ideal for measuring the whole of that particular health concept but the best available measures have been used.

For example, the indicator for alcohol misuse consists of alcohol-related hospital admissions. We know that this does not measure all alcohol misuse, but it still indicates the patterns and trends expected to be present in alcohol misuse as a whole.

More details of how the index is created is available on the ONS website

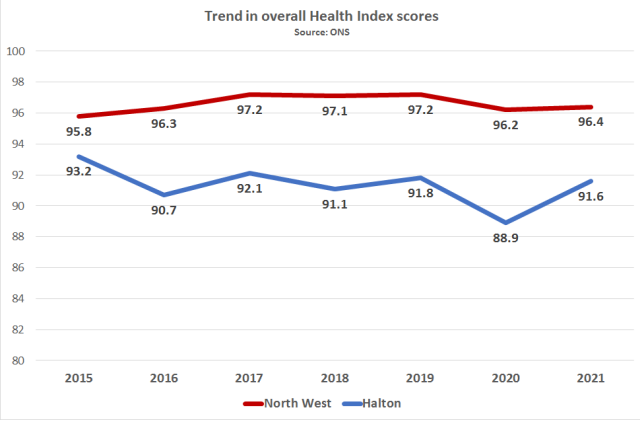
https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandwellbeing/methodologies/healthindexindicatorsanddefinitions#how-we-created-the-health-index

How does Halton fair across the Health Index for England?

For 2021 Halton fairs worse than both the regional and national outlook for Healthy People and Healthy Lives domains but slightly better for Healthy Places.

Area Name	Healthy People	Healthy Lives	Healthy Places
ENGLAND	**97.7**	**100.2**	**104.2**
North West	**91.2**	**94.0**	**105.7**
Halton	**83.4**	**87.3**	**108.2**
Cheshire East	96.3	108.8	114.0
Cheshire West and Chester	99.5	106.6	113.4
Knowsley	76.8	72.4	107.4
Liverpool	77.4	80.4	91.6
St. Helens	91.1	89.8	109.8
Sefton	97.3	92.3	112.0
Warrington	95.3	107.4	110.9
Wirral	84.2	95.3	117.8

The England overall Health Index value is equalised to 100. Trend data shows Halton levels have been consistently below the regional average with both dipping during the 2020 period of the pandemic but recovering to 2019 level in 2021.



There are 26 indicators that make up the Healthy People domain and 22 for each of the other 2 domains. It is therefore not feasible to include them all in this report.

For the Healthy People domain the notable indicators include disability, mental health and musculoskeletal conditions

For Health Lives domain there are a wide range of indicators where Halton fairs worse including alcohol related admissions, healthy eating, educational attainment, teenage pregnancy, hypertension, adult obesity and cancer screening

For Health Places domain Halton is better for green space (open and private), overcrowding and rough sleepers, similar for air pollution but worse for crime, access to GP appointments and job-related training

DRIVERS OF SELF REPORTED HEALTH: Chronic Conditions and multimorbidity

The literature and statistical analysis of survey data within the OHID report suggests that chronic conditions and multimorbidity (having more than one long-term—chronic—health condition) are the clearest drivers for self reported bad health.

Musculoskeletal (MSK) conditions are a particular driver as they have a large population prevalence. Those with chronic MSK conditions have over three times the odds of reporting poor health compared to those without it.

Heart disease, stroke, chronic respiratory conditions, diabetes and mental ill health are also significant factors identified in the literature.

There are two sources of data available to look at these issues, both from primary care. They cannot be compared due to different methodology. Both can be compared to national and regional averages

- The Health Index uses GP patient survey data. This is self reported ill health. It is available at local level only.
- The Quality Outcomes Framework (QOF) is taken direct from GP patient records and is doctor diagnosed data. It is available at ICB sub-location (formerly CCG), Primary Care Network (PCN) and GP practice level. It is not available for all long-term conditions but does cover a wide range.

Musculoskeletal (MSK) conditions

The Health Index shows Halton has worse levels of MSK (patients asked if they suffer from Arthritis or ongoing problems with back or joints) with a value of 93.5 compared to England of 103.3 and North West at 104.2 showing worse MSK levels in Halton.

Prevalence of Rheumatoid Arthritis, 2021/22		
	Register	Prevalence (%)
Runcorn PCN	667	1.22
Widnes PCN	487	0.88
Halton	1,154	1.05
Practice range 0.66 (Newtown to 1.59 (Brookvale)		
Cheshire & Merseyside ICS	18,662	0.83
North West	49,433	0.79
England	388,931	0.77
Source: QOF via NHS Digital		

QOF only includes a register for rheumatoid arthritis. The latest available data for 2021/22 shows patient prevalence is higher in Halton than comparators.

Mental Ill Health

As with MSK levels of depression and mental illness are higher in Halton than comparators. There is wide variation across practices.

Depression prevalence, 2021/22		
	Register	Prevalence (%)
Runcorn PCN	10,214	19.27
Widnes PCN	8,815	16.31
Halton	19,029	17.78
Practice range 9.11 (Peelhouse) to 30.74 (Hough Green)		
Cheshire and Merseyside	350,948	16.00
North West	945,727	15.46
England	**6,235,456**	**12.65**
Source: QOF via NHS Digital		

Mental illness (psychosis) prevalence 2021/22		
	Register	Prevalence (%)
Runcorn PCN	618	0.92
Widnes PCN	566	0.83
Halton	1,184	0.88
Practice range 0.47 (Upton Rocks) to 1.18 (Oaks Place)		
Cheshire & Merseyside	29,146	1.07
North West	82,578	1.07
England	587,025	0.95
Source: QOF via NHS Digital		

However prevalence is lower than comparators for severe mental illness (psychosis)

The Health Index data (from the GP patient survey) supports the picture above when people were asked if they had a mental health condition. The Halton score of 91.8 was worse than England (95.0) and North West (95.0). Taking other mental health issues in to account such as hospital admissions due to self harm and suicides gives an even lower score. Together these provide a picture of worse mental health problems in the borough than comparators.

DRIVERS OF SELF REPORTED HEALTH: Chronic Conditions and multi-morbidity

Cardiovascular disease, Stroke and chronic respiratory disease

The Health Index shows Halton has worse levels of physical health conditions overall than the North West and England.

	Halton	North West	England
Physical Health Conditions	97.5	102.7	101.2
Cancers	109.5	102.5	99.6
Cardiovascular disease	97.6	101.8	102.1
Diabetes	98.7	103	100.2
Respiratory conditions	93	100	94.3

Source: ONS

QOF prevalence data again shows for most conditions Halton has worse health status for all the main long-term conditions identified in the OHID research.

	Halton	Cheshire & Merseyside	North West	England
Atrial fibrilation	2.49%	2.55%	2.20%	2.09%
Hypertension	15.95%	15.36%	13.97%	14.54%
Coronary Heart Disease secondary prevention	4.18%	3.63%	3.44%	3.01%
Stroke & TIA	2.00%	2.06%	1.98%	1.81%
Asthma	7.64%	6.98%	7.06%	6.47%
COPD	2.98%	2.53%	2.39%	1.87%
Diabetes	8.45%	7.22%	7.42%	7.26%
Cancers	3.67%	3.79%	3.43%	3.34%

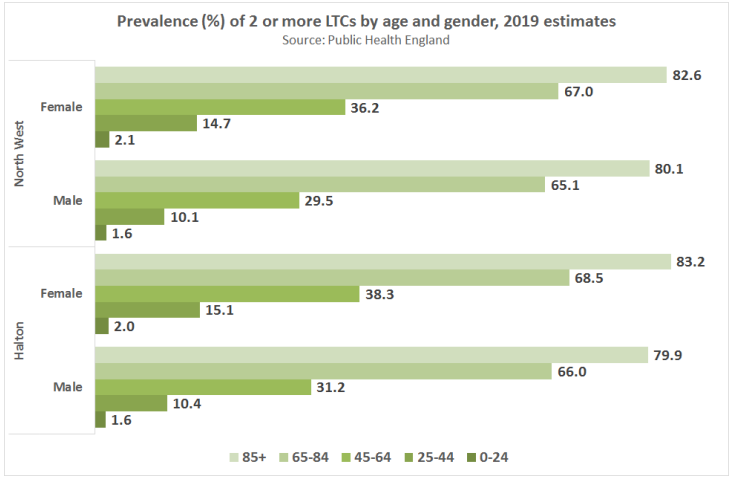
Source: QOF via NHS Digital

Multimorbidity

According to NHS England around one in four adults have two or more long-term conditions (LTCs), often known as 'multi-morbidity.' This rises to two thirds of people aged 65 years or over. Care for people with multi-morbidity is complicated because different conditions and their treatments often interact in complex ways. Despite this, the delivery of care for people with multiple long term conditions is still often built around the individual conditions, rather than the person as a whole. As a result, care is often fragmented and may not consider the combined impact of the conditions and their treatments on a person's quality of life.

Data on levels of multi-morbidity are not available in routine datasets. Analysis by Public Health England (now OHID) in 2019 showed multi-morbidity as well as physical and mental health comorbidity increased with age. There tended to be more people with multiple long-term conditions than there were with physical and mental health comorbidity alone. In females multi-morbidity is strongly associated with area deprivation, but not in early and later life. Men aged 85+ in the least deprived areas have higher levels of multi-morbidity (2+ conditions) than their counterparts in the most deprived.

Prevalence of 2 or more long-term conditions (LTCs) in Halton is similar to the regional averages apart from males 45-64 and females 45-64 and 65-84 which were statistically higher. National comparator data is not available



RISK FACTORS FOR SELF REPORTED BAD HEALTH

Individual lifestyle risk factors

The OHID analysis compared a range of risk factors from the literature and conducted analysis of survey findings against them. They calculated something called an odds ratio. Simply put, how likely was someone who for example was physical inactive to report their health was bad compared to someone who was physically active.

An odds ratio (OR) of 1 would suggest the levels were the same, an OR above 1 suggests likelihood is higher and an OR of less than 1 that likelihood is lower.

Nationally, for self-reported poor health, physical activity has an OR of 2.5 for those inactive compared to those meeting the guidelines for physical activity and an OR of 1.8 for those with low/some activity. So those who are sedentary are 2.5 times as likely to report poor health.

Smoking is the other significant lifestyle factor with an OR of 1.76 for current smokers compared to those who do not smoke.

Halton has a higher percentage of adults who are physically inactive compared to England. However it is statistically similar. For smoking, prevalence has reduced considerably and Halton's rate is now nearly the same as England at 13.2% compared to England at 13%.

So whilst these two lifestyle factors show significant associations with poor self-reported health, they are likely at similar levels to England not higher.

Better 95% | Similar | Worse 95% | Not compared

Recent trends: – Could not be calculated | → No significant change | ↑ Increasing & getting worse | ↑ Increasing & getting better | ↓ Decreasing & getting worse | ↓ Decreasing & getting better

Percentage of physically inactive adults 2021/22

Proportion - %

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	-	22.3	22.1	22.5
CAM23	–	-	-	-	-
St. Helens	–	-	26.8	22.8	30.8
Knowsley	–	-	25.2	21.4	29.1
Liverpool	–	-	24.8	22.9	26.7
Sefton	–	-	24.5	20.6	28.5
Halton	–	-	23.7	19.8	27.5
Wirral	–	-	22.8	19.1	26.4
Cheshire West and Chester	–	-	22.1	18.6	25.8
Warrington	–	-	21.1	17.4	24.9
Cheshire East	–	-	20.7	17.4	24.4

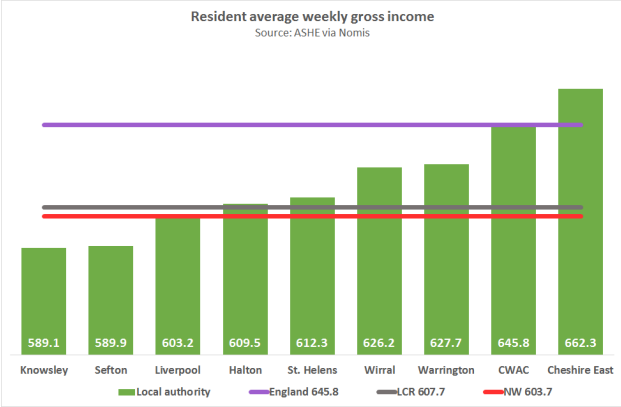
Source: Active Lives Survey, Sport England via OHID Fingertips profile

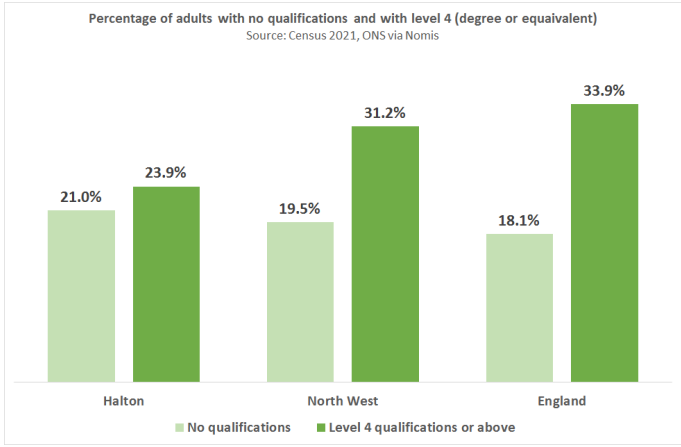
Wider determinant risk factors

It is not just medical or lifestyle factors that impact on whether people report than their health is good or bad. A number of social factors also influence this.

Household income has the highest OR for reporting poor health; 1.8 for those in the lowest quintile of income compared to the highest quintile of income. Those with no qualifications an OR of 1.65 compared to those whose highest qualification was at degree level or equivalent. Those living in areas with the highest levels of deprivation were more likely also to report poor health compared to those living in the least deprived areas, with an OR of 1.4. Halton is the 27th most deprived local authority in England (IMD 2019).

Halton data shows that residents in the borough earn on average less than the national averages, the 4th lowest across Cheshire & Merseyside.





Census 2021 data shows a lower percentage of Halton residents have degree or above level qualifications than the regional or national averages.

These social factors are likely to exert a greater influence of self reported poor health and nationally.

MORTALITY

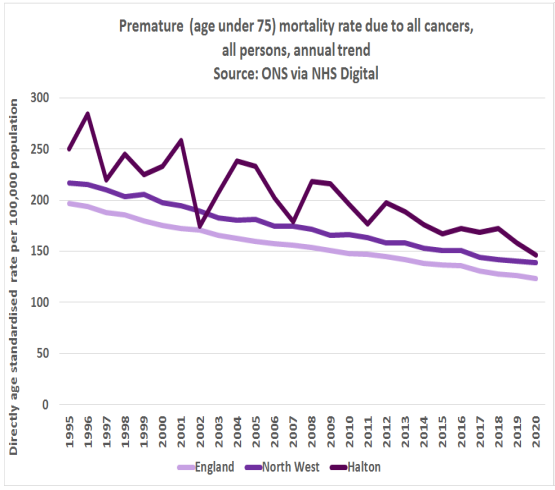
Introduction

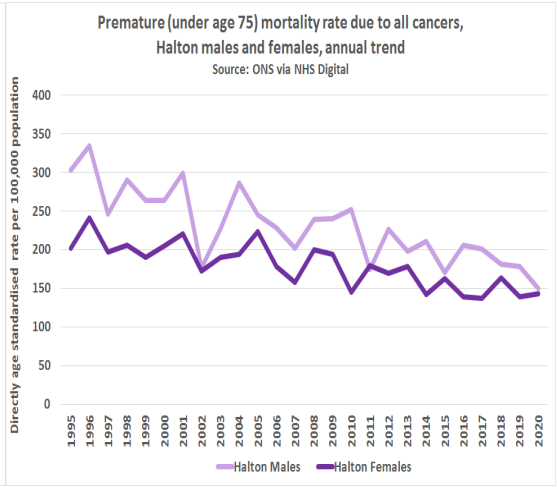
The OHID report also looks at the causes of death and risk factors which influence life expectancy. It is based on analysis of the most common causes of years of life lost (YLL) in England in 2019 using the Global Burden of Disease (GBD) study. The GBD provides modelled data on YLL, which are years lost due to premature mortality (defined as death age under 75). Deaths from cancer and cardiovascular disease make the largest contribution to YLL and will therefore have the biggest impact on life expectancy.

Local analysis of causes of death also show cancers and cardiovascular disease as the top two causes of all deaths.

Cancers

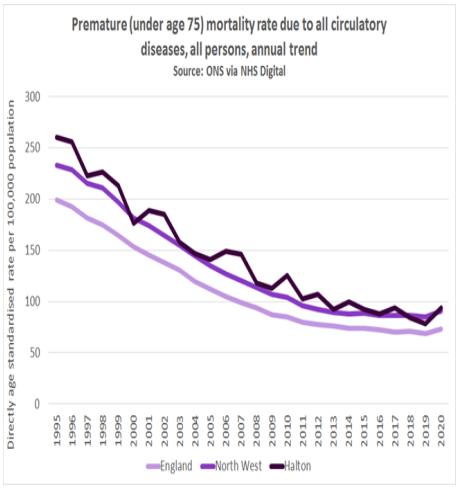
There has been a substantial fall in the rate of premature deaths from cancers. Data from 1995 shows a gap in cancer rates between men and women. However, rates amongst women have not fallen as sharply as for men and by 2020 the gender difference was marginal.

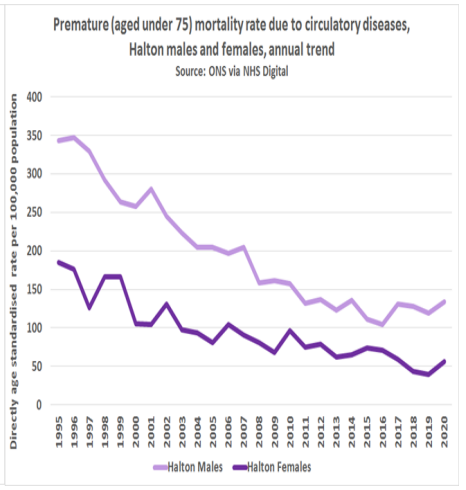




Cardiovascular disease

Premature deaths from all circulatory diseases have also fallen over this 1995 to 2020 time period, for both males and females. Like cancers, in 1995 rates for males were much higher than for females. Unlike cancers there is still a gender difference up to more recent years albeit the gap has narrowed.



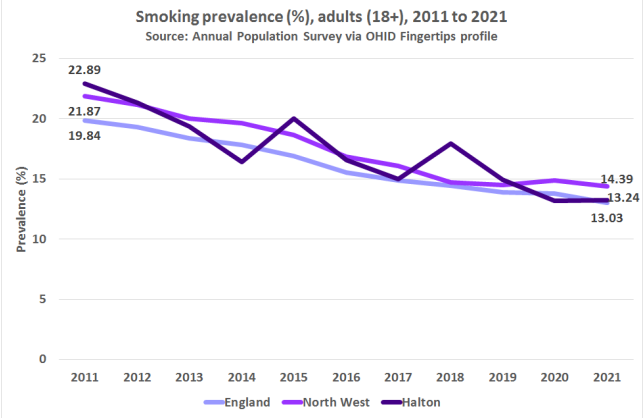


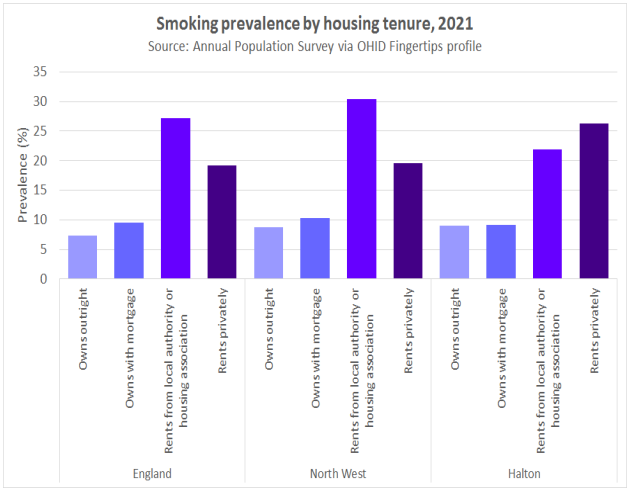
RISK FACTORS ASSOCIATED WITH MORTALITY

Smoking prevalence

The national report shows tobacco is the risk factor making the largest contribution to YLL for both sexes. This is followed by dietary related risks including high body mass index (BMI), high cholesterol and high blood pressure.

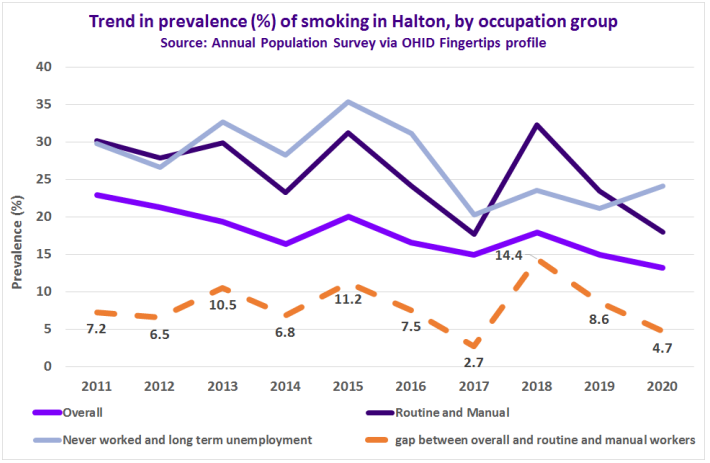
Smoking prevalence in Halton has decreased over the last decade with rates now similar to the England average.



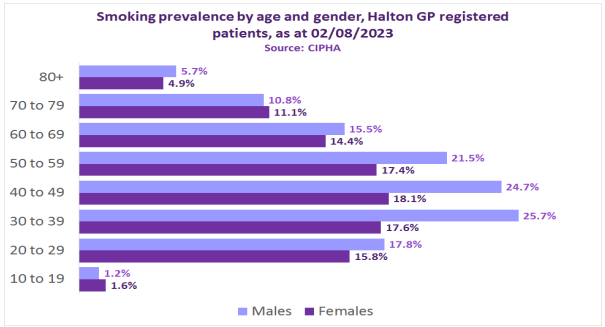


However rates vary by both housing tenure and my occupation type. Unlike the regional and national averages, smoking prevalence in Halton is higher in those in the private rented sector than the social rented sector. However, it is clear that smoking prevalence is highest amongst those who rent their home compared to those who own it and that is consistent with comparators.

The gap between the overall prevalence and that amongst those in routine and manual occupations has decreased in 2021 but it s too early to say if this is a on-off change or more long lasting.

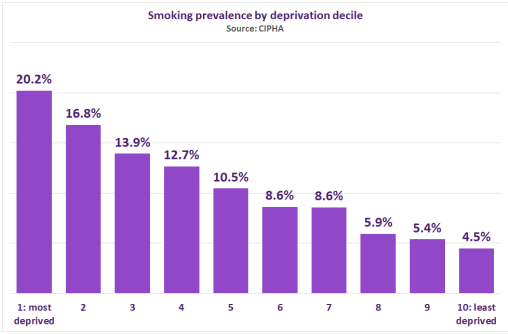


Data from general practice shows slightly higher prevalence amongst men, that those identifying as white ethnic background have the highest rates and a clear relationship with deprivation; those living the the most deprived decile having a prevalence rate five time that of the least deprived (20.2% compared to 4.5%)



	Currently smoke	Total Population	Prevalence
White	14,173	100,883	14.0%
Other Ethnic Groups	1,465	10,955	13.4%
Refused and not stated group	697	5,031	13.9%
Mixed	529	3,803	13.9%
Asian or Asian British	78	1,122	7.0%
Black or Black British	56	604	9.3%

Source: CIPHA

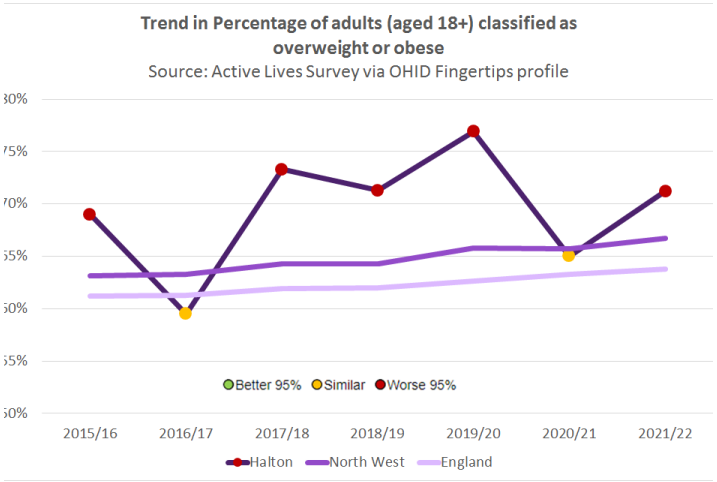


RISK FACTORS ASSOCIATED WITH MORTALITY

Obesity

The NHS Long Term Plan commits to a targeted offer of support and access to weight management services in primary care for people with a diagnosis of hypertension or type 2 diabetes with a BMI >30, (adjusted appropriately for ethnicity) amongst other actions to reduce obesity.

Levels of adult obesity are generally statistically worse in Halton than the national average and also higher than the regional average.



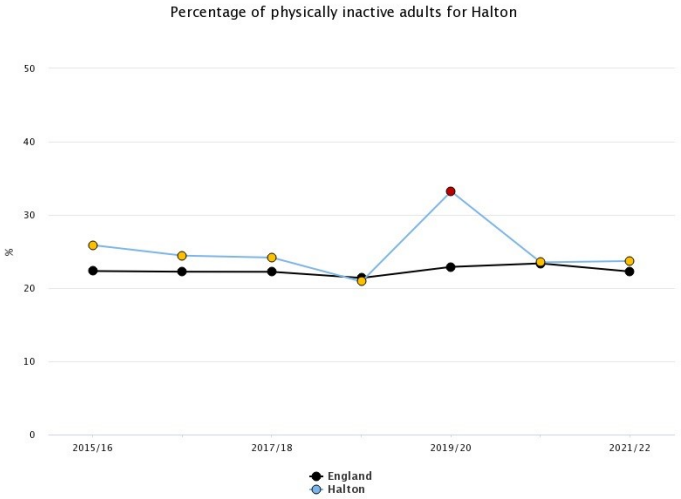
Halton has the second highest level of adult excess weight (overweight and obese) of the nine local authorities in Cheshire & Merseyside.

Percentage of adults (aged 18 plus) classified as overweight or obese 2021/22 — Proportion - %

Area	Value	95% Lower CI	95% Upper CI
England	63.8	63.6	64.1
C&M 3	-	-	-
Knowsley	74.6	70.4	78.6
Halton	71.2	66.7	75.6
Sefton	71.2	66.6	75.5
Wirral	70.9	66.5	75.1
Warrington	70.6	66.3	75.2
St. Helens	70.2	66.0	74.5
Cheshire West and Chester	65.4	60.8	69.9
Liverpool	65.3	63.0	67.6
Cheshire East	62.5	58.1	67.0

Source: Office for Health Improvement and Disparities (based on the Active Lives Adult Survey, Sport England)

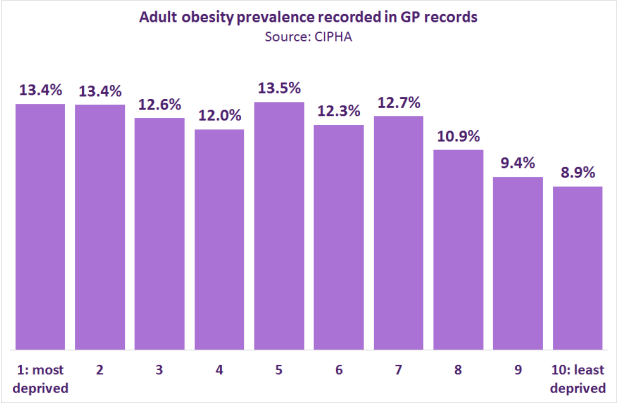
Driving a significant proportion of this is high levels of physical inactivity with over 20% of adults reporting levels of physical activity below government guidelines. However levels are not statistically significantly higher than England. Halton ranks only 5th highest level of phycial inactivity of the 9 Cheshire & Merseyside local authorities (2021/22)



By contrast only 15.89% of adults 9aged 18+) are known to be obese within general practice. Of the 15,259 people who have a recording of a BMI in this category on the GP record only 1,240 have been referred to weight management services in the last 12 months.

Whilst this prevalence is much lower than the Active Lives self-reported data local analysis of the data is possible. It shows a slight deprivation gradient.

It also shows levels slightly higher in women than men with the highest proportion amongst those in aged 59-69.



RISK FACTORS ASSOCIATED WITH MORTALITY

High blood pressure

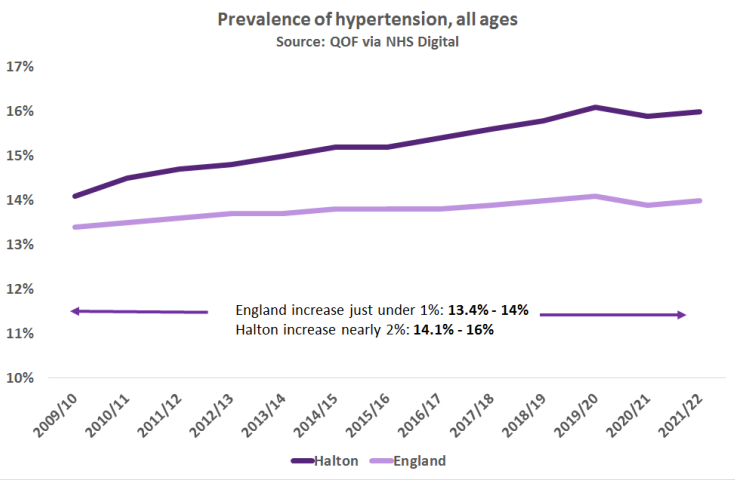
Analysis of the Health Survey for England conducted by the ONS shows:

•An estimated 32% of adults had high blood pressure (hypertension) and 3 in 10 of those (29%) were undiagnosed.

•Adults who were the least likely to have hypertension (such as younger adults-especially men -, those whose general health was good, and those who were not overweight or obese) were the most likely to be undiagnosed if they did have hypertension.

•Although younger adults with hypertension were proportionately more likely to be undiagnosed than older adults, the highest total estimated number of cases of undiagnosed hypertension in the population were among males aged 55 to 64 years and females aged 65 to 74 years.

Hypertension, measured through the GP Quality Outcomes Framework (QOF) shows levels in Halton are higher than the national average and have increased to a greater extent over then last decade. It is not possible to determine if this is due to better identification locally or an increase in absolute population prevalence.



High cholesterol

If there is too much cholesterol in your blood, this can be laid down in the walls of your arteries – the large blood vessels that carry blood around your body. Fatty areas known as plaques can form, and these become harder with time, making the arteries stiffer and narrower. **This process is called atherosclerosis.**

This makes it hard for blood to flow around the body easily. It can lead to a number of diseases of the heart and blood vessels including heart attack and strokes.

Analysis of the Health Survey for England conducted by the ONS shows:

•59% of adults aged 16+ had raised cholesterol. It was highest in those aged 45-64 (72%) and was higher amongst women than men I both the 45-64 and 65+ age groups but not the 16-44 age group where it was higher in men

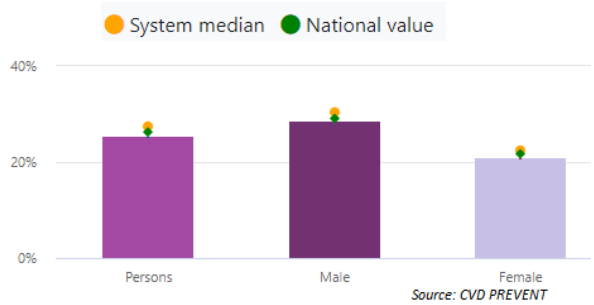
•It was highest in the highest income group and lowest in the middle income group

•It was highest in the 4th most deprived quintile but the relationship with deprivation was not clear cut. The least deprived quintile had the second highest prevalence

•Raised cholesterol levels had been reducing; in 1998 prevalence was 67%. By 2019 it had fallen to 47% but in 2021 had increased to 59%

Data on the prevalence of high cholesterol is not routinely collected. Data from the ICS data tool CIPHA shows 8,339 Halton GP registered patients had atherosclerotic heart disease.

Data from CVD PREVENT shows a lower percentage of Halton patients aged 18 and over, with GP recorded CVD, in whom the most recent blood cholesterol level (measured in the preceding 12 months) is non-HDL cholesterol less than 2.5mmol/l or LDL-cholesterol less than 1.8mmol/l. Than the Cheshire & Merseyside system or national averages. This is the case for both men and women.



CONCLUSIONS

- Life expectancy in Halton has improved but remains below regional and national averages. The gap between the borough and England has remained fairly consistent over time.
- The extra years of life gained are not necessarily spent in good health. For women the number of years spent in poor health has increased over the last decade. However for men it has reduced slightly.
- Healthy life expectancy is driven to a greater extent by self reported health than mortality. As such any improvements in self-reported health will increase HLE more then improving mortality rates.
- Halton has higher proportions of its population reporting poor health compared to regional and national averages.
- The Census provides a rich data source to understand this. It shows:
  - Age is a significant factor, levels of reported poor health increase with age
  - Gender also is important with women more likely to report poor health than men
  - Those identifying as White Irish and White British have the highest levels of self reported poor health
  - Disabled people have much higher levels of self reported poor health. This is the case from the youngest to the oldest age groups
  - Those providing unpaid care also have higher self reported poor health, especially those providing 50 or more hours care per week
  - Single people had the lowest percentage reporting poor health. However, single men had higher levels of poor health compared to single women. Levels were highest amongst those divorced and especially widows. This is especially so for women
  - Nearly half those with no qualifications reported poor health compared to just over 15% of those with level 4 (degree and above) qualifications
  - Other vulnerable groups include military veterans, homeless and those identifying as a non-UK national especially those residing in the UK for less than a year
- The ONS Health Index shows Halton scores below the regional and national levels meaning it has poorer health. This is split into 3 domains: health outcomes, healthy lives and healthy places. Halton scores below on the first two but better for healthy places.
- The drivers for poor self reported health are chronic physical and mental health conditions plus a person having more than one chronic condition (multi morbidity). Musculoskeletal (MSK) conditions, mental health, cardiovascular disease (CVD), respiratory disease and diabetes are important factors.
- Halton has worse levels of MSK (patients asked if they suffer from Arthritis or ongoing problems with back or joints) than the region or national levels. QOF shows prevalence of rheumatoid arthritis specifically is higher.
- The borough also has higher levels for all the other main conditions important to self reported poor health apart from cancers (based on QOF doctor diagnosed conditions). It has slightly higher levels of males and females in the 45-64 and 65-84 age groups with 2 or more long-term conditions
- Levels of physical inactivity and smoking impact on the likelihood of self reported poor health. Levels in Halton are similar to the national averages. There is a significant relationship between smoking and both occupational group and deprivation. Obesity levels are statistically higher which has an impact on mortality
- Income levels, deprivation and educational attainment are also important drivers and here the borough does worse than the national averages
- Mortality rates for cancers have improved. Halton's rates do remain higher than England. However the improvement is less marked in women. Traditionally cancer rates were higher in men but the gap is now marginal.
- CVD mortality rates have also improved and for both genders. They remain higher in men. They also remain higher than the national average rates
- Halton has high prevalence of hypertension and worse management of high blood cholesterol which are both drivers for CVD mortality