

St.Helens

Joint Strategic Needs Assessment

2018

4. Adults - Lifestyles



St.Helens
Council

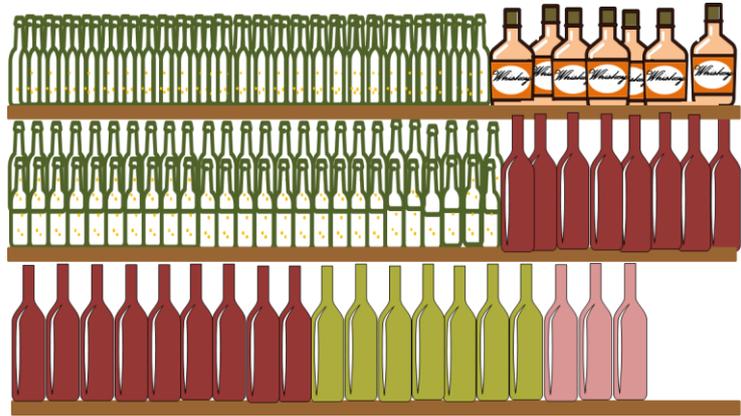


St Helens Clinical Commissioning Group

Alcohol

Local rates of hospital admissions due to alcohol are the 13th highest of 152 authorities in England.

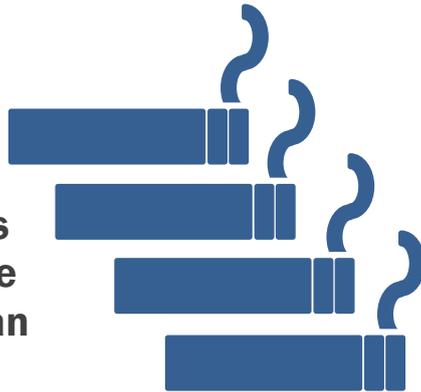
In 2014, off-trade alcohol sales in St.Helens were enough for every adult to drink 7 bottles of spirits, 27 bottles of wine and 101 pints of beer.



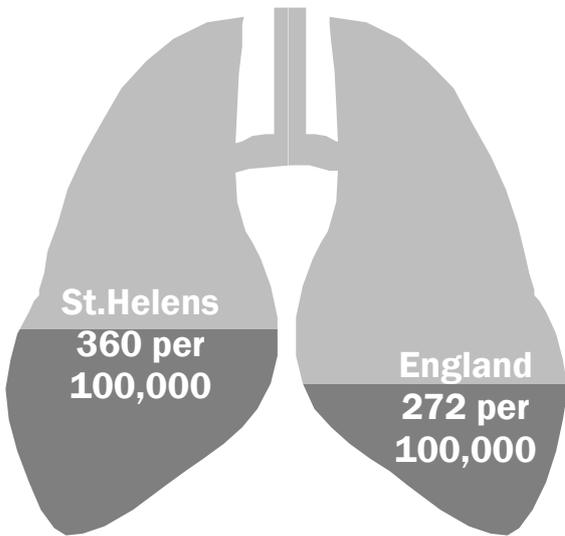
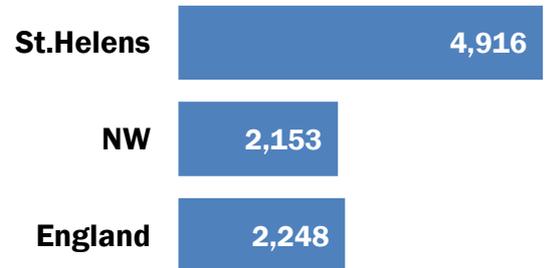
Tobacco



Smoking prevalence is four times higher in the most deprived ward than the least deprived



Local rates of smoking quitters are twice the national average



Smoking attributable mortality is higher than the England average

Weight

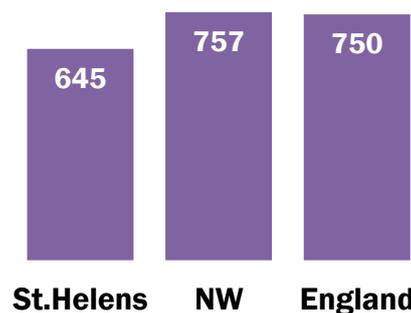


2 out of 3 adults in St.Helens are carrying excess weight

Substance misuse

The estimated rate of opiate use in St.Helens is higher than the North West and England averages

Sexual health



Rates of new STI infections are significantly below the national average

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1. Introduction

A wide range of factors can impact on an individual's health and wellbeing. Age, gender and family history of illness are examples of factors that an individual has no control over. However, lifestyle factors such as smoking and obesity also have a large impact on health, both individually and at the population level and can be influenced.

This section of the 2018 Joint Strategic Needs Assessment explores adult lifestyle factors to determine the level of need and to gain a better understanding of adult health and wellbeing in St.Helens. Many of the health harms from these issues are proportionally greater in St.Helens than found nationally. It is also important to measure these lifestyle factors, since long-term trends are of increasing concern in some areas, such as obesity.

2. Key Findings

a. Alcohol

- Alcohol-specific mortality for men is higher than the national and North West averages.
- While rates remain high, the three-year alcohol-specific mortality rate for women has fallen every year between 2010-12 and 2014-16, which is very positive.

b. Tobacco

- Smoking attributable mortality in St. Helens is significantly higher than the national average (359.8 and 272.0 respectively).
- The proportion of adults that are current smokers has decreased slightly from previous years and St. Helens remains above the North West and national averages, although the gap is decreasing.
- The St. Helens rate of smokers who became successful quitters in 2016/17 was the highest rate in the North West region and the 6th highest rate nationally.

c. Obesity and Physical Activity

- 72.1% of adults in St. Helens are estimated to have excess weight (overweight or obesity). This corresponds to more than 100,000 adults within the Borough.
- According to the Active Lives Survey, 26% of the adult population in the UK is not active at levels to benefit their health.¹ Approximately 29% of adults in St. Helens do not meet physical activity recommendations, doing less than 30 minutes of moderate intensity activity per week.
- St. Helens has the highest proportion of the population with nearby access to woodland in the North West of England.

d. Substance misuse

- St. Helens has an estimated number of 1,386 users of opiates or crack cocaine, including an estimated 280 injecting drug users.
- At the end of 2015/16, there were a total of 1276 individuals that had received structured drug treatment.
- In 2015/16 there were a total of 15,287 transactions taking place at St. Helens needle and syringe programmes.

e. Sexual health

- In 2016, the rate of STIs diagnosed in St. Helens (including chlamydia) was 645 diagnoses per 100,000, (1,146 cases), which is significantly lower than the England average of 750 per 100,000.
- In 2016 the detection rate for chlamydia in young people aged 15-24 years (2,144 per 100,000) was significantly higher than the England rate (1,882).
- The overall prevalence of HIV infection in St. Helens in 2016 is 0.99 per 1,000 15-59 year olds. This rate is significantly lower than the national average (2.31 per 1,000).

¹ <https://www.sportengland.org/media/12458/active-lives-adult-may-16-17-report.pdf> data tables at LA level available, for 16+ and excludes gardening. The new PHOF indicator states age 19+ and includes gardening.

3. Alcohol

Alcohol consumption and its associated consequences are a major public health challenge. Whilst most people drink alcohol responsibly, there are still many who drink to excess. Across England in 2016/17, there were 298,797 hospital admissions episodes specifically due to alcohol and in 2016/17 there were 80,454 adults who received specialist alcohol treatment.² It is estimated that nationally, alcohol-misuse costs around £21bn per year in healthcare, crime and lost productivity costs.³

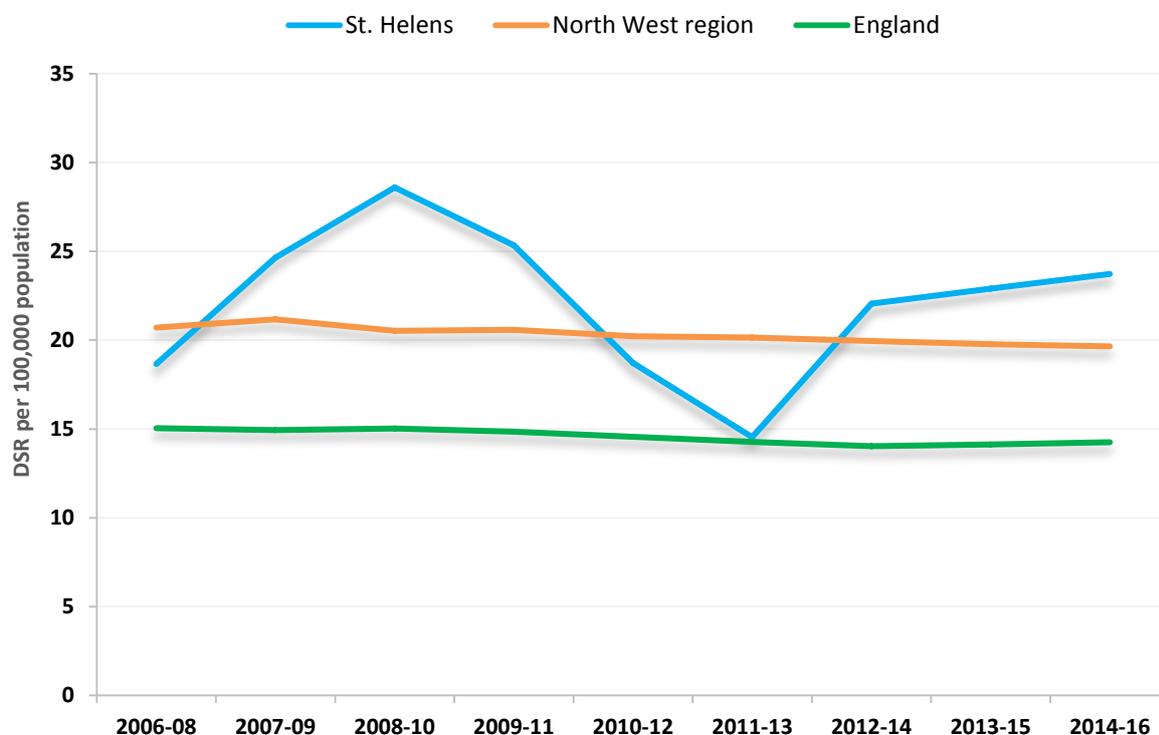
3.1 Mortality due to Alcohol

3.1.1 Alcohol-Specific Mortality

3.1.1.i Males

The male alcohol-specific mortality rate in St.Helens (23.7 per 100,000) for 2014-16 is higher than the North West average of 19.7 per 100,000 and significantly higher than the England average of 14.2 per 100,000. There were 61 male alcohol specific deaths in 2014-16 (3 year period). Since a peak in 2008-10 the male alcohol-specific mortality rate has reduced by 17%; equating to 13 fewer deaths. The rate had dipped to a low of 14.5 per 100,000 in 2011-13 which was lower than regional average and in-line with national, but has since risen again in the last 3 periods.

Figure 1. Alcohol-Specific Mortality: Males trend



Source: Local Authority Profiles for England (LAPE), 2017, PHE

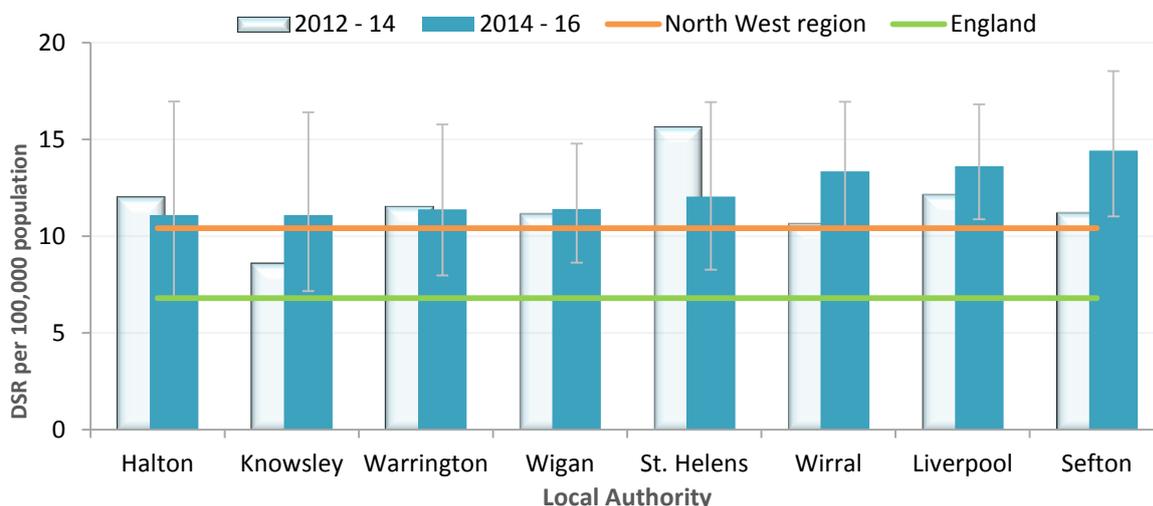
² Public Health England, Local Alcohol Profiles for England, <http://fingertips.phe.org.uk/profile/local-alcohol-profiles>

³ Alcohol concern <https://www.alcoholconcern.org.uk/help-and-advice/statistics-on-alcohol/>

3.1.1.ii Females

Between 2012 and 2014, the female alcohol-specific mortality rate in St.Helens was the second highest of all unitary and lower tier local authorities in England (16 deaths per 100,000). However the rate has fallen over recent years and the rank has dropped to seventeenth highest in England (12 deaths per 100,000). There were 33 alcohol specific deaths in females in 2014-16.

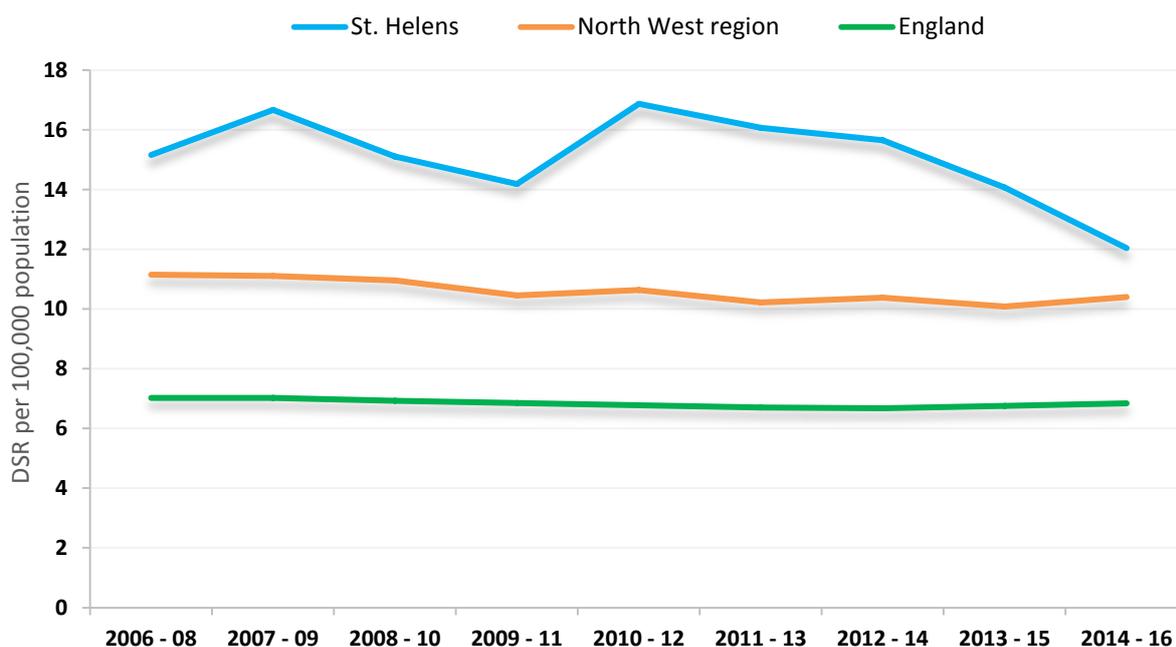
Figure 2. Alcohol Specific Mortality: Females 2012-14 and 2014-16



Source: LAPE, 2017, PHE

Nationally the rate of alcohol-specific mortality in women (6.8 per 100,000) is about half of that for men (14.2 per 100,000). In St.Helens for 2014-16, the female rate is similarly around half the male rate. While rates remain high, the three-year alcohol-specific mortality rate has fallen every year between 2010-12 and 2014-16 which is very positive.

Figure 3. Alcohol-Specific Mortality: Females trend



Source: Local Authority Profiles for England (LAPE), 2017, PHE

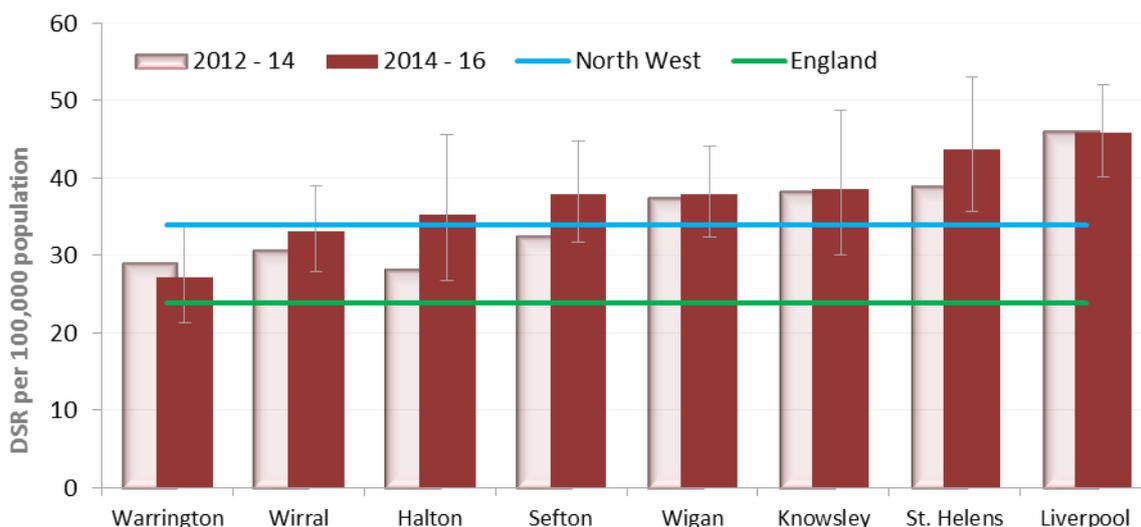
3.1.2 Mortality from Chronic Liver Disease

In St.Helens, the mortality rate for 2014-16 from chronic liver disease in all persons ranks is the 7th worst of 152 upper tier local authorities, and the rate has increased by 3.8% compared with the 2012-14 value.

3.1.2.i Males

The mortality rate from chronic liver disease in males has increased over recent years, by 12% since 2012-14 and by 27% since 2010-12. The mortality rate for St.Helens is the fourth highest in England.

Figure 4. Mortality from Chronic-Liver Disease: Males 2014-16

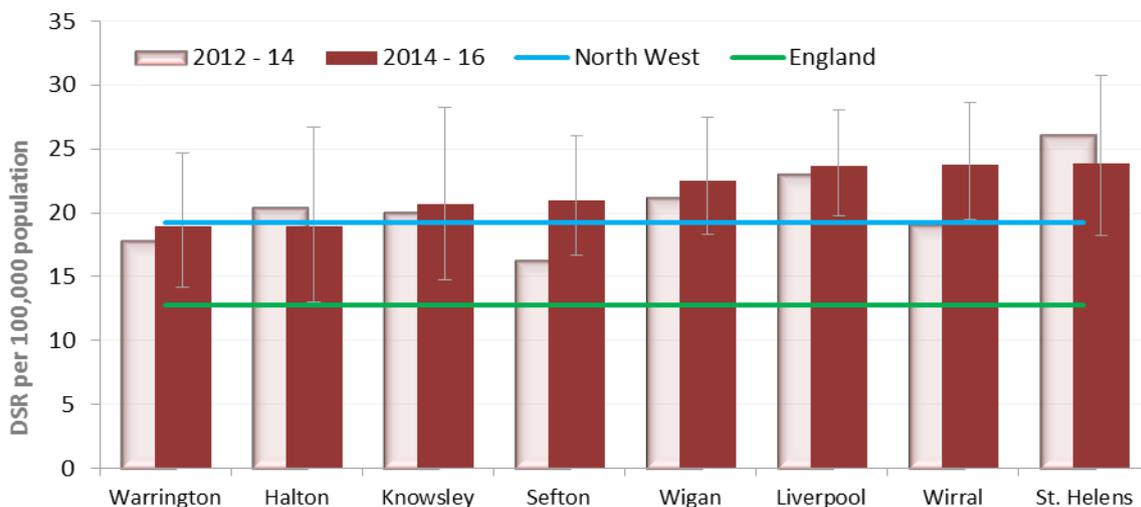


Source: Liver Disease Profiles, 2017, PHE

3.1.2.ii Females

For women in St.Helens, the mortality rate from chronic liver disease is significantly higher than the national average, but is not statistically different to the North West average. The local rate has decreased by 8.7% since 2012-14.

Figure 5. Mortality from Chronic-Liver Disease: Females 2014-16



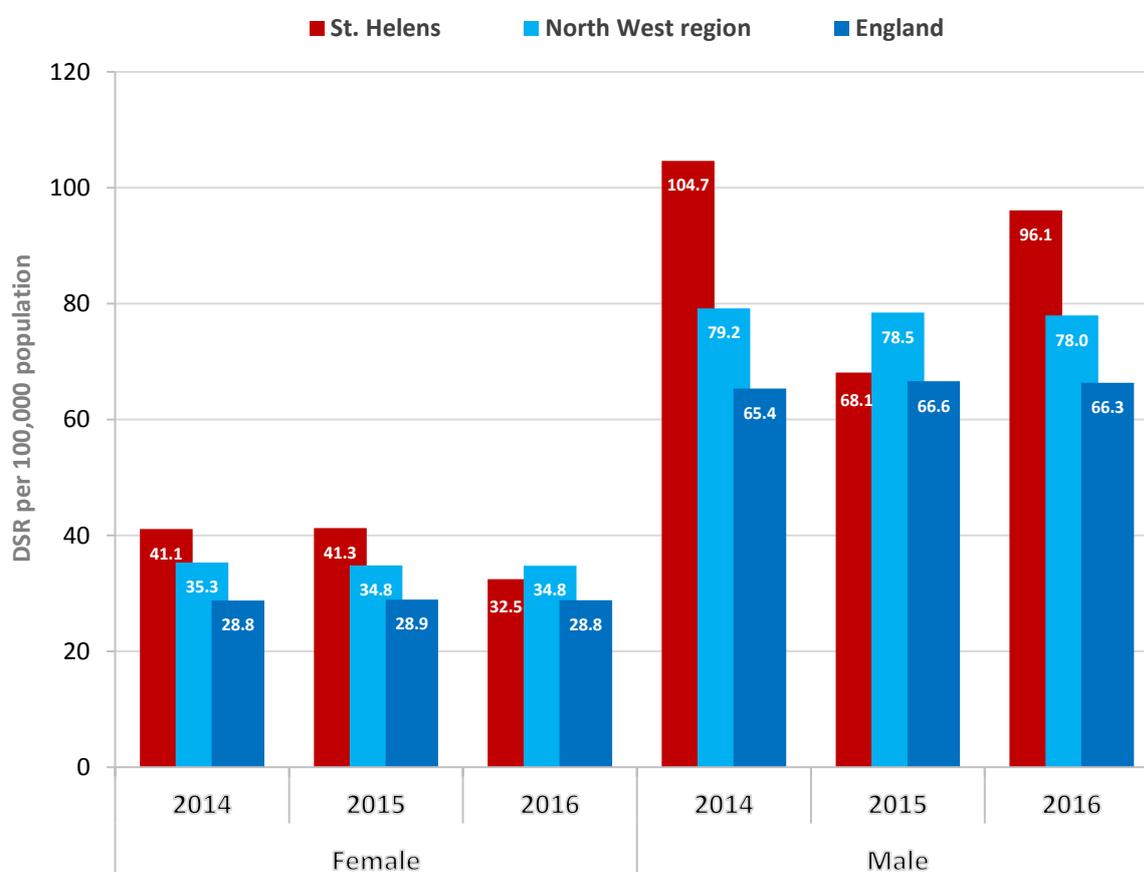
Source: Liver Disease Profiles, 2017, PHE

3.1.3 Alcohol-Related Mortality

Alcohol related conditions include all alcohol specific conditions, plus those where alcohol is casually implicated in some but not all cases of the outcome, for example hypertensive diseases, various cancers and falls. There are 152 upper tier and unitary local authorities in England. Of these, St.Helens had the 10th highest rate for mortality from alcohol-related conditions in 2016.

The rate for alcohol-related mortality in males has been volatile over recent years, with the 2016 rate lower than that in 2014, but higher than that from 2015. The rate is now higher than the national (66.3) and North West regional (78.0) averages. The rate for females has decreased and although still slightly higher than the national average, it is now lower than the North West regional average.

Figure 6. Alcohol-Related Mortality (2016)



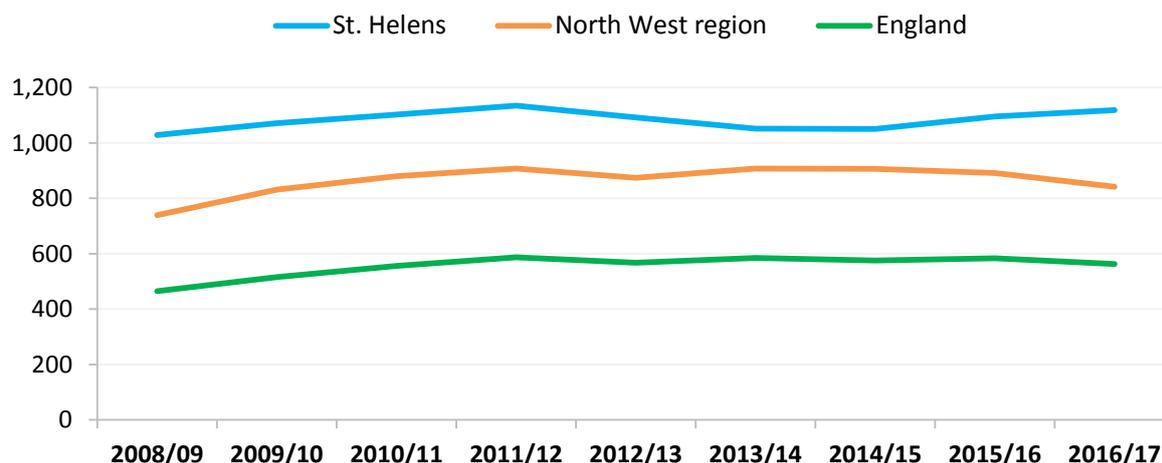
Source: LAPE, 2017, PHE

3.2 Hospital Admissions

3.2.1 Alcohol-Specific Hospital Admissions

Alcohol-specific hospital admissions in 2016/17 in St.Helens have increased since 2014/15 by 6.4%; the regional and national averages have decreased slightly. In St.Helens the increase equates to an additional 47 hospital admissions from the previous year. St.Helens ranks in the 5th worst position for 2016/17, compared with 152 upper tier and unitary local authorities in the country.

Figure 7. Alcohol-Specific Hospital Admissions

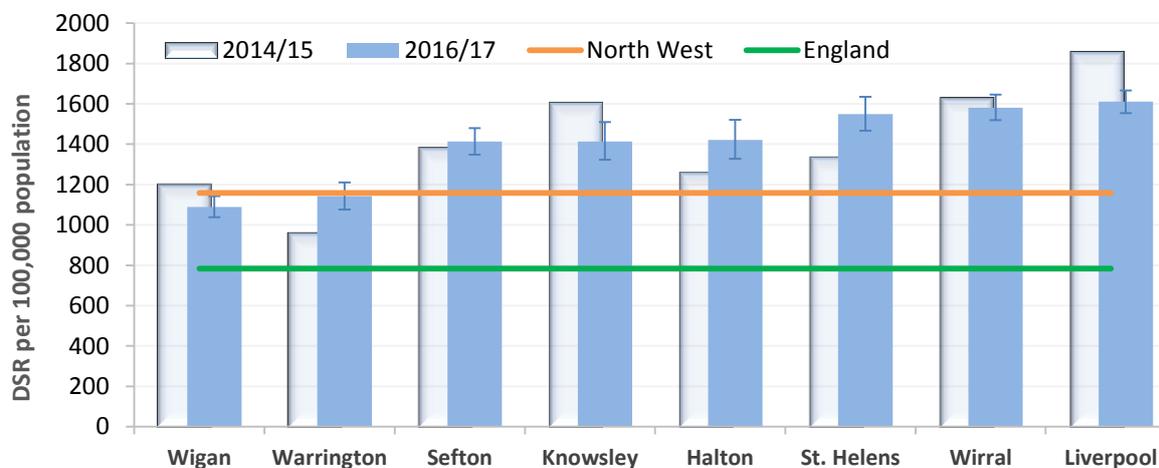


Source: LAPE, 2017, PHE

3.2.1.i Males

The rate of male alcohol-specific hospital admissions in 2016/17 (1,550 per 100,000 population) is higher than the regional and national averages. The rate of admissions has increased since 2014/15 by 16%, whereas the regional average has decreased by 7% and the national average decreased by 2%.

Figure 8. Alcohol-Specific Hospital Admissions: Males 2016/17



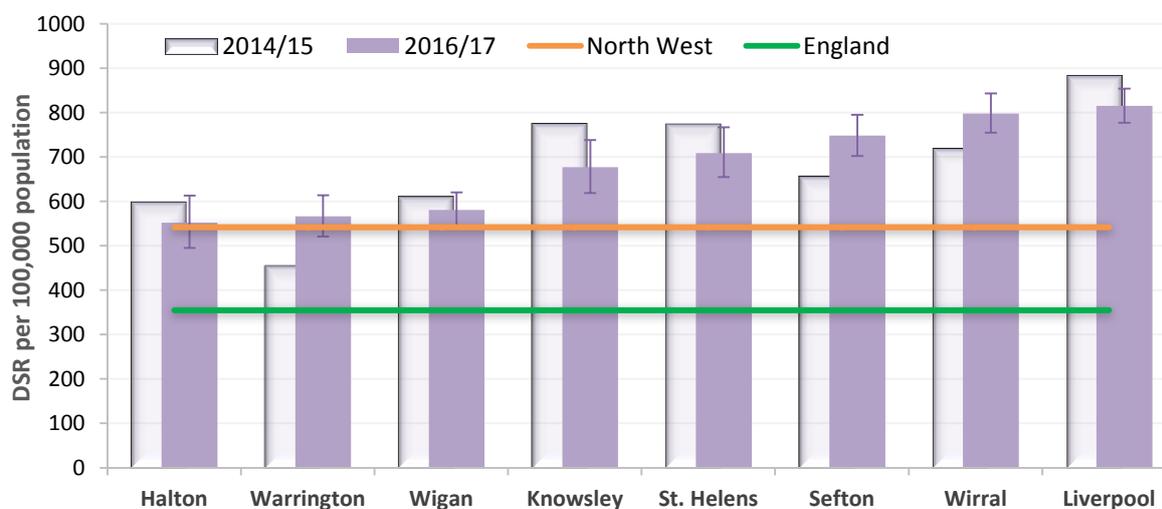
Source: LAPE, 2017, PHE

In St.Helens, alcohol-specific hospital admissions in males' rank 7th highest (worst) compared against 152 UAs in the country.

3.2.1.ii Females

The rate of alcohol-specific hospital admissions in females in St.Helens is the 6th highest (worst) in England with double the England rate (709 and 355 per 100,000 population respectively). Seven of the ten authorities with the highest admission rates nationally are in the North West. Since 2008/09 this equates to an additional 167 hospital admissions. Over the past 9 years the rate has increased by just 7.5%, whereas the North West rate has increased by 22.3%, and the England rate has increased by 29.7%.

Figure 9. Alcohol-Specific Admissions: Females 2015/16



Source: LAPE, 2017, PHE

3.3 Consumption and Availability

3.3.1 Sales

Public Health England has produced local estimates of off-trade alcohol sales based on regional store data. Over 1m litres of pure alcohol were sold from off-licensed premises in St.Helens in 2014. At an average of 7.3 litres per adult, this is the fifth highest amount in the North West, and the 18th highest of all local authorities in England. Almost 2 litres of this was spirits.

Figure 10. Volume of pure alcohol sold through the off-trade: all alcohol sales, 2014

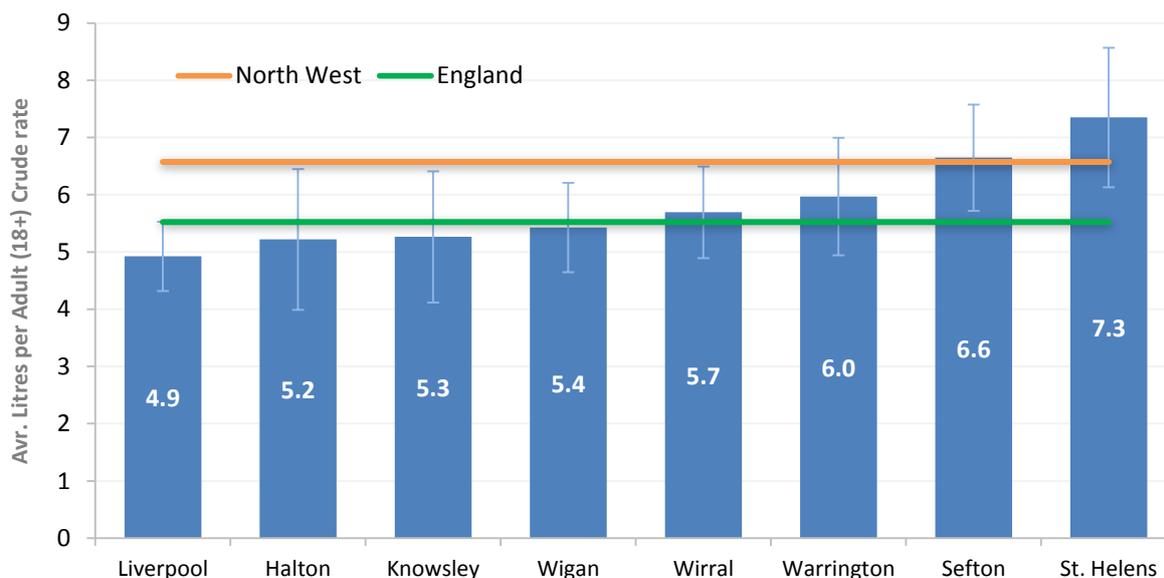


Figure 11. Volume of pure alcohol sold through the off-trade: Spirit sales, 2014

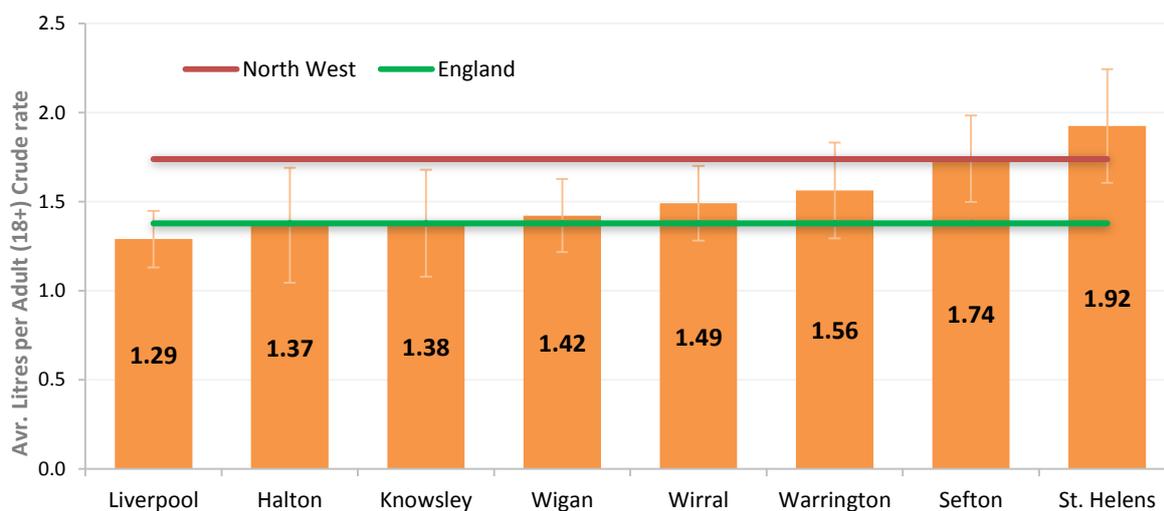


Figure 12. Volume of pure alcohol sold through the off-trade: Wine sales, 2014

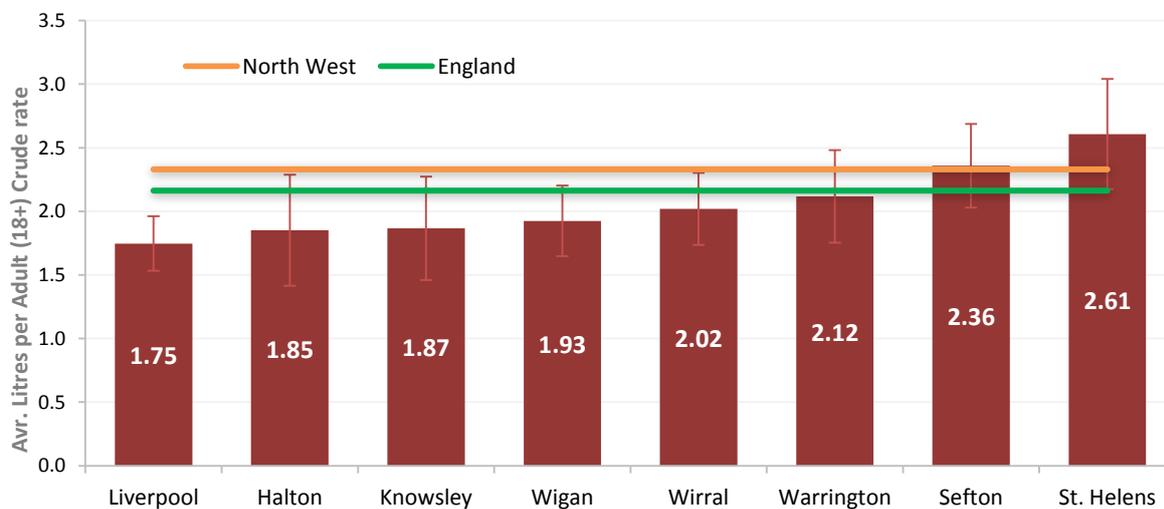
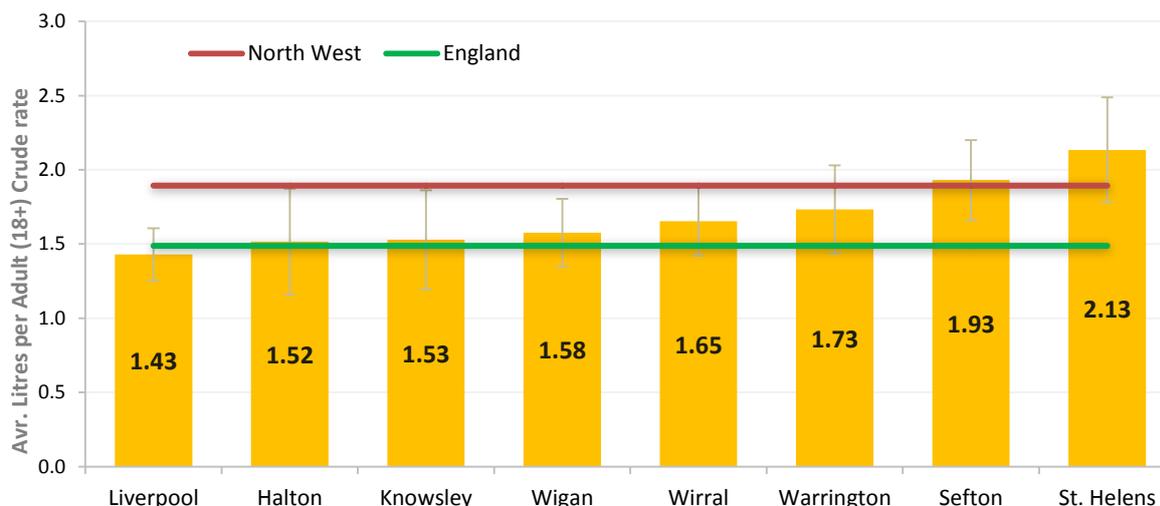


Figure 13. Volume of pure alcohol sold through the off-trade: Beer sales, 2014

Source: LAPE, 2017, PHE

The estimated sales per person aged 18 years and over for St. Helens in 2014 are:

- 1.92 litres of pure alcohol from spirits
- 2.61 litres of pure alcohol from wine
- 2.13 litres of pure alcohol from beer

As this is in pure alcohol, the corresponding volume in typical bottles would be:

- 6.8 bottles of 40% spirits per adult, per year, (70cl, 4.76 l)
- 26.8 bottles of 13% wine per adult, per year, (75cl, 18.7 l)
- 101 pints of 4% beer per adult, per year (57 l)

(Please note this is an overall average and would be expected to vary significantly from person to person).

3.3.2 Trend

In total, the 7.3 litres of alcohol included in the figures for off-licence sales would correspond to an average of 14 units per person per week (730 units per year).

Therefore the estimated sales of off-licence alcohol in 2014 were enough for every adult in the Borough to drink at the recommended weekly limits. True figures will be higher still, as the off-licence data does not include every retailer and on-licence sales will further increase consumption.

Nationally, sales of alcohol have fallen over recent years. Across England and Wales in 2005, the average consumption of pure alcohol across on and off-licences was 10.5 litres of pure alcohol per person per year. This had fallen to 9.1 litres per person in 2015, a fall of 13% over the ten years. However, this is due to a reduction in on-trade sales in pubs and restaurants. Sales in off-licences actually had a small increase from 6.1 litres of pure alcohol per person in 2005 up to 6.3 litres per person in 2015. Sales in licenced premises fell from 4.4 litres per person in 2005 down to just 2.8 litres in 2015.

In the same time period, average price per unit increased significantly in licenced premises from £1.07 per unit in 2005 up to £1.67 per unit in 2015. The average price per unit in off-licenced premises had a smaller rise, going from £0.40 per unit in 2005 to £0.53 per unit in 2015. Therefore the average price per unit for on-licence sales across England and Wales increased by 56% over the last ten years, at the same time as the volume of alcohol sold per person reduced by 36%. However, for off-licence sales, the average price per unit increased by 32%, and the total volume sold increased by 3%. However, due to the higher base price, the average increase in price per unit in licenced premises is greater than the actual average price per unit sold in off-licences and supermarkets.

3.3.3 Consumption

Alcohol-related harm is determined by the volume of alcohol consumed and the frequency of drinking occasions. As such, the risk of harm is directly related to levels and patterns of consumption.

The following indicators show the proportion of the adult population in the borough who abstain from alcohol, and those at risk of alcohol-related harm from their current consumption behaviour.

Figure 14. Percentage of the adults who abstain from drinking alcohol, 2011-2014

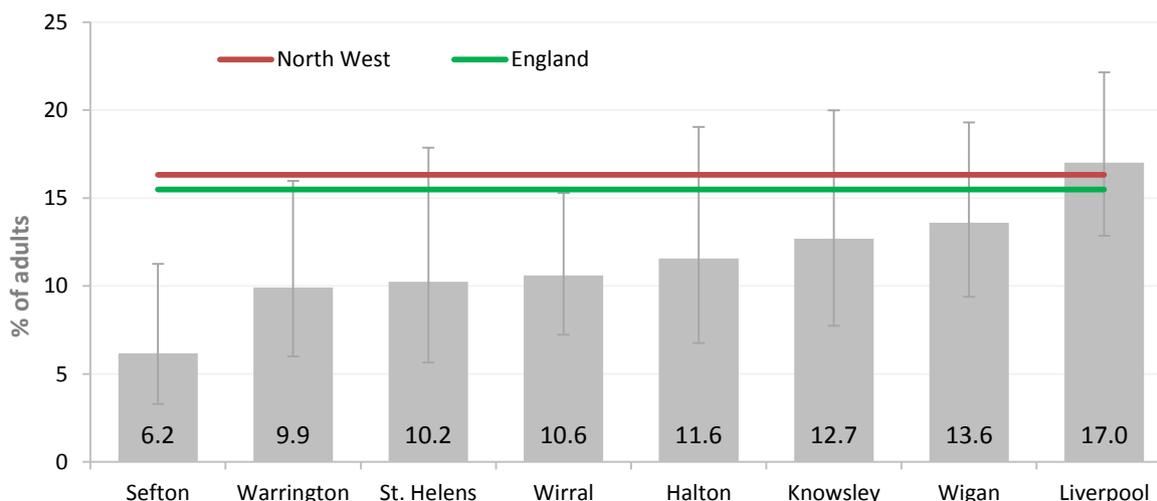


Figure 15. Percentage of adults drinking over 14 units of alcohol a week, 2011-2014

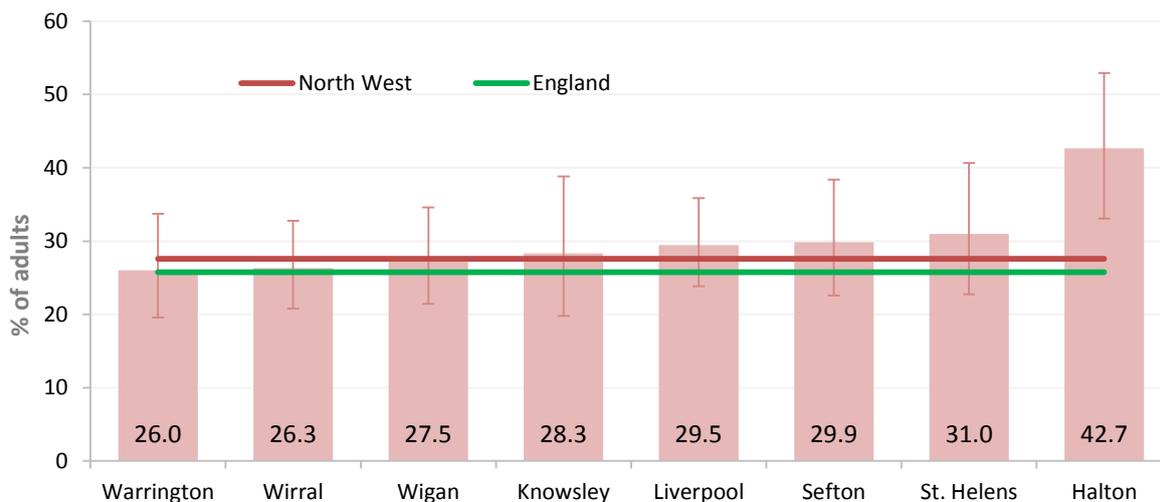
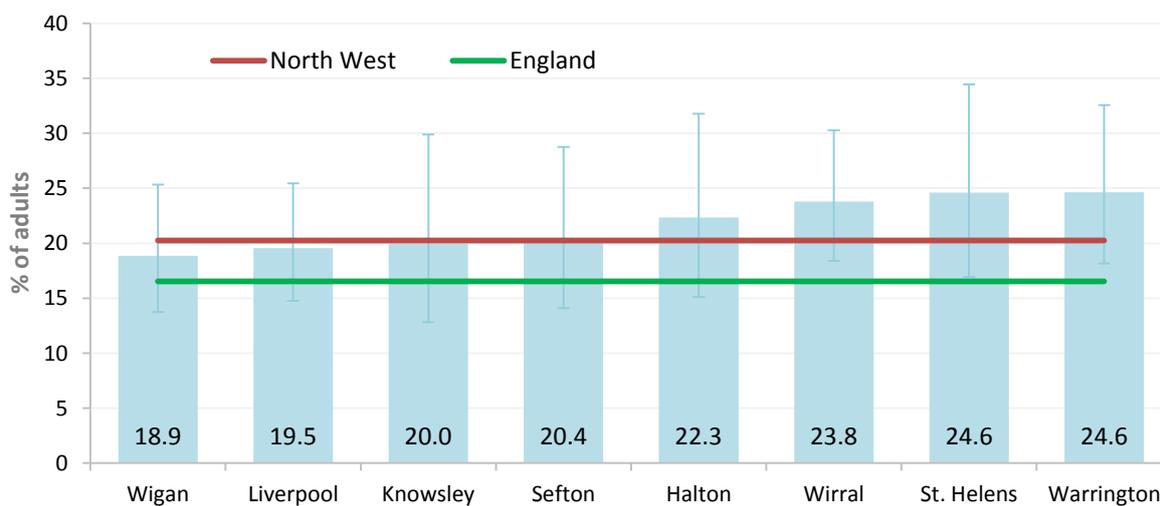


Figure 16. Percentage of adults binge drinking on heaviest drinking day, 2011-2014



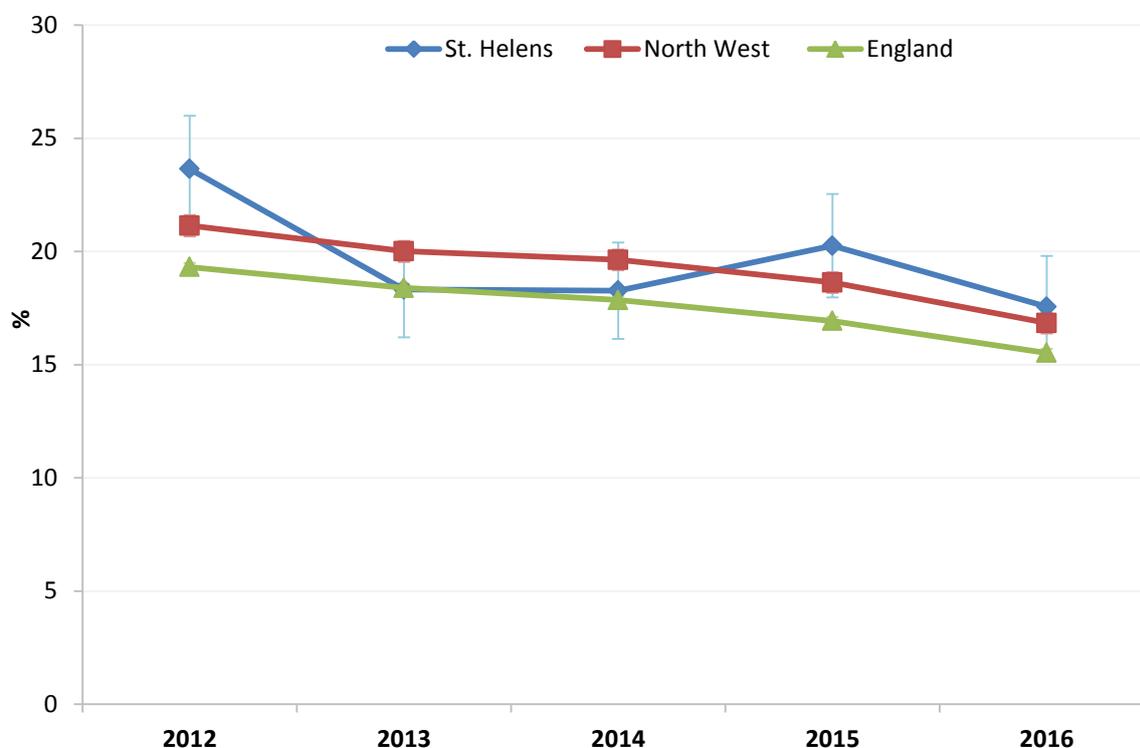
4. Tobacco

Tobacco smoking is the biggest cause of avoidable death nationally, and is responsible for about half of the health inequality in life expectancy between social groups. The national policy has been to reduce the prevalence of tobacco smoking through reducing the uptake of smoking in young people and helping existing smokers to stop. Tobacco control measures to restrict advertising and de-normalise smoking are as important as services to help smokers to quit.

4.1 Smoking Prevalence

According to the APS (Annual Population Survey) the prevalence of smokers in St Helens in 2016 is 17.6%. This is slightly higher than the North West (16.8%) and England (15.5%) prevalence. The smoking rate has decreased slightly from 2015 (20.3%) in St. Helens.

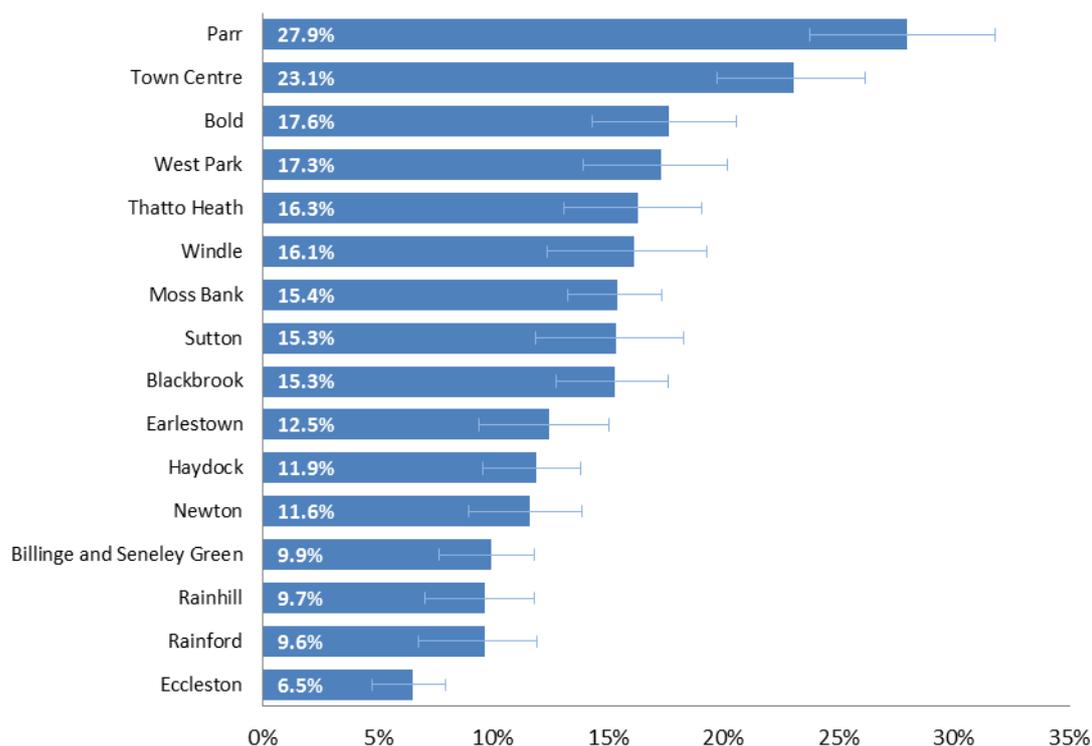
Figure 17. Smoking Prevalence (current smokers - all persons age 18+)



Source: APS (Annual Population Survey) PHOF

The 2015 Merseyside Fire and Rescue Services Home Fire and Safety Checks give an indication of how smoking rates vary across the borough. The overall proportion of recorded smoking for St. Helens on the survey is 14.3% which might be lower than expected, and is lower than the most recent result from the Annual Population Survey of 17.6%. However the ranking between wards may still be useful and are given in Figure 10 below.

Parr and Town Centre wards were estimated to have significantly higher smoking rates than all other wards. This would be expected to have an impact on mortality rates in Parr and Town Centre.

Figure 18. Estimated ward smoking prevalence based on Merseyside Fire & Rescue data

Source: Merseyside Fire and Rescue Service 2015

4.2 Inequalities in Smoking

Smoking accounts for over half of the health inequalities between social groups in England. There are large differences between smoking rates in different groups that lead to differences in health outcomes.

4.2.1 Deprivation

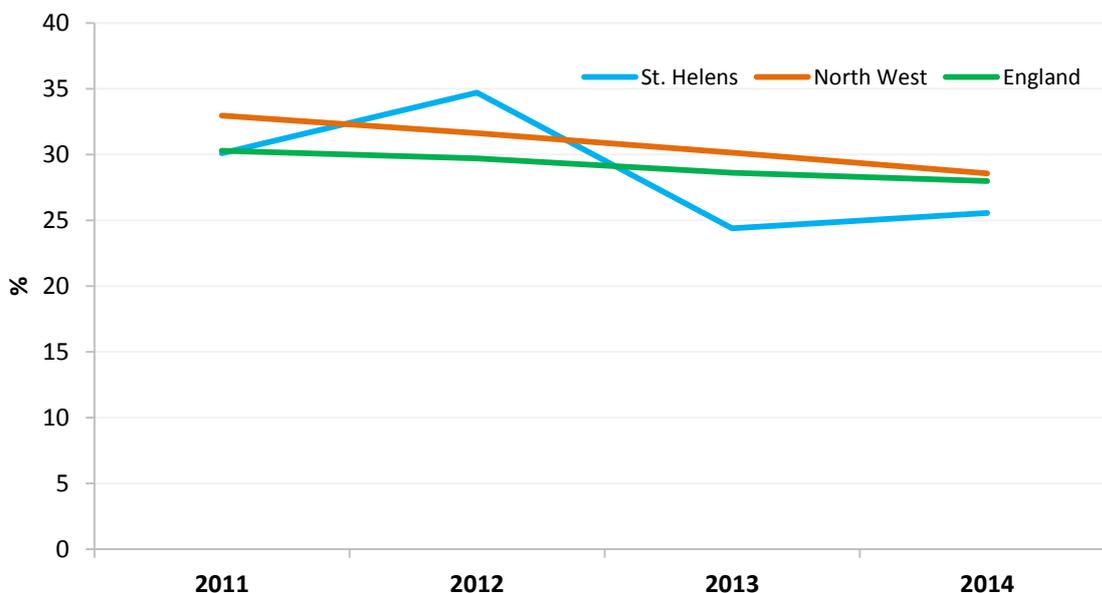
In England there are higher rates of smoking among people with manual occupations, people without qualifications, people who are divorced or separated, people who are unemployed, people who live in rented housing, people who receive income support and people with low wellbeing.

Smoking rates are high among people with mental health conditions. People with longstanding anxiety, depression or another mental health condition are twice as likely to be smokers as those who do not have any mental health problems. Rates of smoking increase with the severity of the disorder, ranging from 25% among people with eating disorders to 56% of those with probable psychosis. Nationally around 80% of prisoners smoke. Over the last 20 years, smoking prevalence has changed little in those with severe illness.

4.2.2 Employment

Smoking prevalence in adults in routine and manual occupations is higher with 26.2% being current smokers in St. Helens (2014). The smoking rate for St. Helens has decreased since 2012 and in 2014 (latest available data) is below the North West (26.8%) and England (26.5%) rates, both of which have also seen a decline from previous years.

Figure 19. Smoking prevalence in adults in routine and manual occupation



Source: Integrated Household Survey. PHE

4.2.3 Age

ASH (Action on smoking and health) reports that it is estimated that each year around 207,000 children in the UK start smoking. Of those adults that smoke, roughly two-thirds stated they took up smoking before the age of 18 and over 80% before the age of 20.

4.2.4 Older People

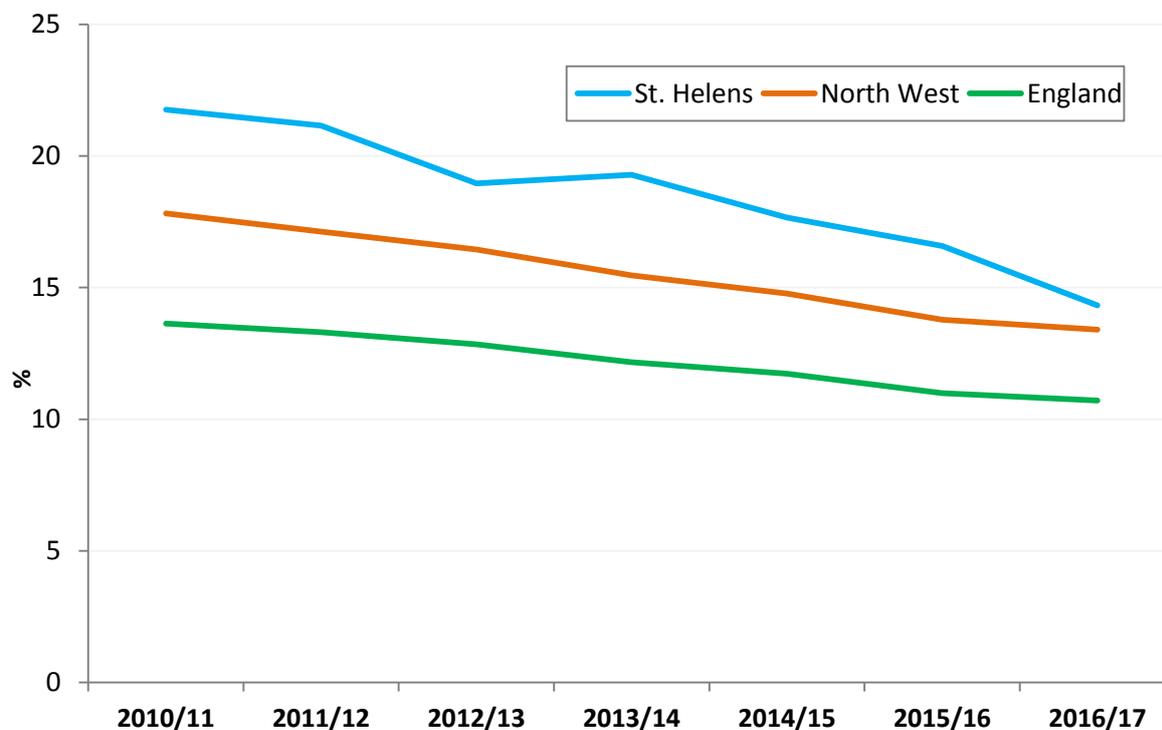
The smoking cessation rates are high amongst those over 65 years. Over half (55%) of those who smoked have now given up compared to 29% of 18-64 year olds (Lifestyle Survey, 2013).

Statistics on NHS Stop Smoking Services in England (2015/16) show that the success rate of giving up smoking generally increase with age. The highest proportion of successful quitters was in those aged 60 and over (57%) compared with those aged 18 and under (43%).

4.2.5 Pregnancy

The prevalence of smoking at time of delivery is 14.3% in St Helens which is worse than England and the North West prevalence (10.7% and 13.4% respectively). However it has fallen by 34.4% since 2010/11 from 21.8% to 14.3%.

Figure 20. Smoking prevalence in pregnant women



4.2.6 Mental Health

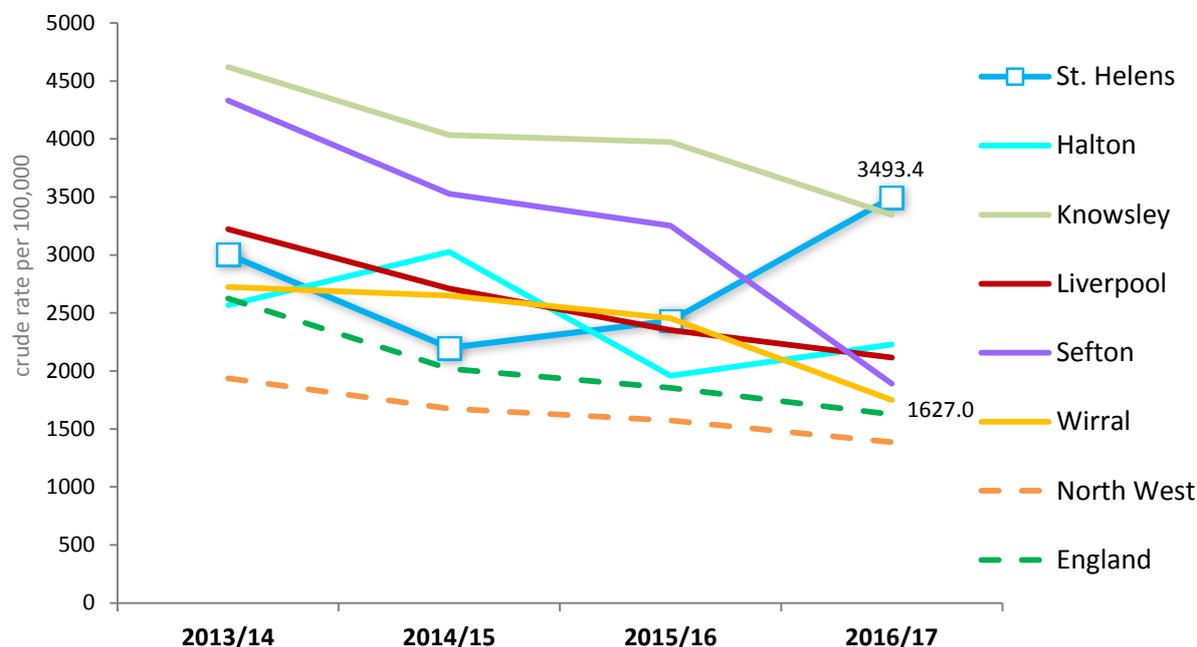
Smoking prevalence amongst people with a mental health illness is significantly higher than in the general population.

The Health Survey for England (2014), found that almost a third of men and a quarter of women who had ever been diagnosed with a mental illness were current smokers (31% and 23% respectively). This was much higher than the population average of 17.5% of men and 13.7% of women (Smoking Prevalence in adults - current smokers, 2016).

The Health Improvement Network (THIN) has GP medical records from around 8 million patients across the United Kingdom. This data estimates that there are approximately 2.6 million smokers in the UK with a common mental condition and around 3 million with a mental condition of any kind. This means that approximately 30% of the 10 million smokers in the UK have a mental condition.

4.2.7 Quitters

Figure 21. Successful quitters (CO validated⁴) at 4 weeks per 100,000 smokers (16+ years)



Source: PHE Local Tobacco Profiles 2018

The St.Helens rate of succesful quitters in 2016/17 (3,493 per 100,000 population) is the highest amongst 23 North West region local authorities and the 8th highest out of 152 local authorities nationally (6th highest in the non-CO validated indicator). The St.Helens rate is more than double the national rate of 1,627, which is a very positive result.

⁴ Carbon Monoxide (CO) validation measures the level of carbon monoxide in the bloodstream and provides an indication of the level of use of tobacco: it is a motivational tool for clients as well as validation of their smoking status. CO validation is attempted on all clients who self-report as having successfully quit at the 4-week follow-up, except for those who were followed up by telephone.

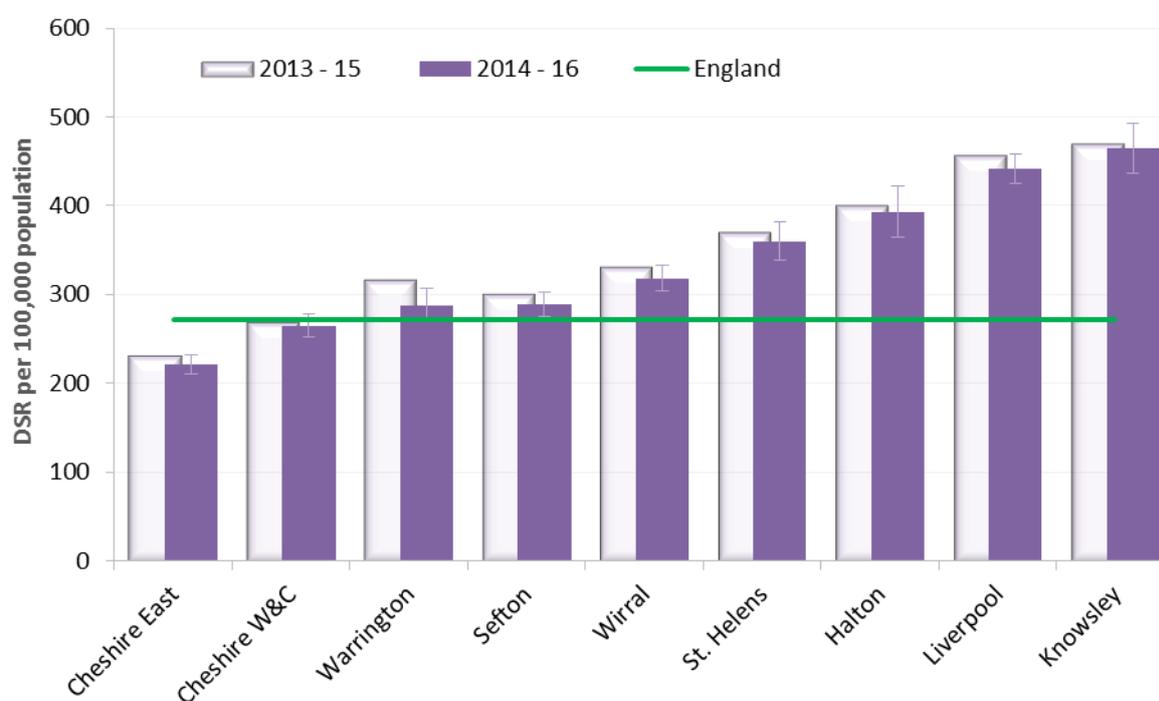
4.3 Impact of Smoking

Tobacco use is estimated to cost the St.Helens economy £48.8m per year. The costs include costs to local businesses of £31 million in loss of productivity, £3 million due to sickness absence and £13 million due to early deaths. In addition smoking costs the NHS in St.Helens £7.2 million annually and over £4.1 million is spent on social care as a result of smoking.⁵

4.3.1 Attributable Mortality

- Smoking attributable mortality in St. Helens is significantly higher than the national average (359.8 and 272.0 respectively). Smoking attributable mortality is somewhat reflective of historic smoking prevalence in St. Helens.

Figure 22. Smoking attributable mortality in Cheshire and Merseyside compared to England (2014-2016)



Source: ONS mortality file; Integrated Household Survey/APS, PHE

a. Use of Health Services

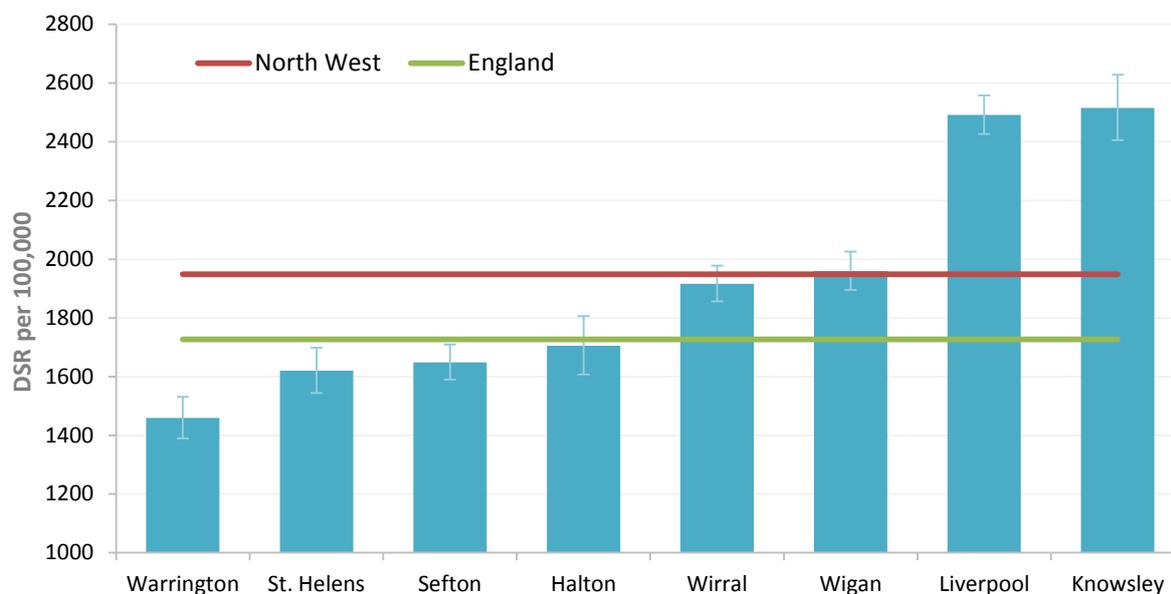
Smoking leads to respiratory conditions, circulatory disease, cancers and is a risk factor for a number of chronic health conditions. Smoking attributable hospital admissions in St. Helens are lower than regional and national averages; however the cost per capita of smoking attributable hospital admissions in St. Helens is slightly higher than the national average but slightly lower than regional.

⁵ <http://www.ash.org.uk/localtoolkit/>

4.3.2 Attributable Hospital Admissions

- St.Helens has the 4th lowest rate of smoking attributable hospital admission of the twenty-three North West regional local authorities. This is also lower than the regional and national rates.

Figure 23. Smoking attributable hospital admissions, 2015/16



4.4 Local Views

- Surveys of smokers have shown that approximately 2 out of 3 smokers want to stop smoking. Evidence suggests that people are three times more likely to quit and stay quit by accessing stop smoking services.
- There has been strong local support for measures taken to de-normalise smoking and help prevent young people from starting. This has included voluntary Smokefree areas including Smokefree touchlines at sports clubs, and Smokefree playgrounds introduced locally. There is also good support for national measures such as restricting smoking in cars with children and for standardised packaging. A recent 2015 survey of residents found that 94% were in favour of outdoor family events being Smokefree.

4.5 Use of E-Cigarettes

- E-cigarettes have become increasingly popular over recent years. They deliver nicotine in a vapour form and are used in a similar way to smoking (vaping).
- An estimated 2.8 million adults in Great Britain currently use electronic cigarettes up from only 700,000 in 2012 (Action on Smoking and Health, 2016).
- Over the last few years e-cigarettes are predominantly used by smokers as a partial or total replacement for smoking. Although many young people have tried e-cigarettes, few adults or children who don't smoke have taken up e-cigarettes and this hasn't been shown to lead to smoking.

- The main reason given for using electronic cigarettes among current e-cigarette users and ex-smokers is 'to help me stop smoking tobacco entirely' with 67% stating so.
- There have been some concerns about the quality and safety of e-cigarettes. Public Health England concluded in a review of evidence that the risks are minimal compared with the health risks of smoking. For smokers changing to using e-cigarettes will reduce the harms to their health.
- Smokefree St.Helens service welcomes smokers who wish to use e-cigarettes to stop smoking. The service also welcomes e-cigarette users who wish to stop. The service will prescribe e-cigarettes once these have been licenced.
- A study (Smoking Toolkit Study) by University College London found that in 2015 more quit attempts involved use of an e-cigarette (39.5%) than licensed NRT (26.4%). This equated to more than 1 million smokers who used an e-cigarette compared with around 700k using a licensed NRT.
- In St.Helens, 43% of 14-16 year olds said they had tried an e-cigarette, which was higher than the North West average of 37%.⁶ The most common method to obtain e-cigarettes was from friends, (it is illegal to sell e-cigarettes to under 18s).

⁶ Young Persons' Alcohol, Tobacco and E-Cigarette Survey 2017

5. Obesity & Physical Activity

5.1 Obesity

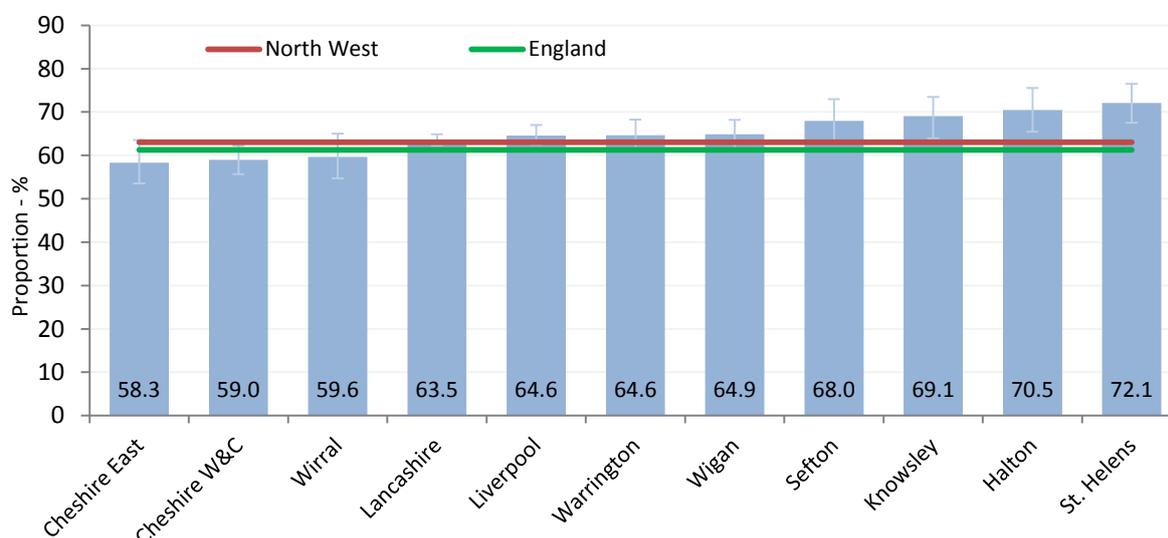
Excess weight (overweight and obesity) affects the majority of adults within the Borough and is a substantial public health issue that impacts on individual wellbeing and quality of life, as well as the wider economy, placing strain on businesses, health and social services.

Being obese increases the risk of depression, cancer, cardiovascular disease, diabetes, high blood pressure, high cholesterol, respiratory diseases, arthritis, stroke and more.^{7,8,9,10} These conditions can significantly reduce people’s quality of life and subsequently increase the number of persons with limiting long term conditions, reducing independence and also increasing the number of persons taking sick days or reporting being unable to work. The wider costs of obesity to the UK is thought to be £27bn, with 16m obesity sick days, obesity medication costing £13.3m, a cost to the NHS of £5.1bn and a cost to social care of £352m.¹¹ In St.Helens this is estimated to equate to £47m to the wider economy, with a cost to the NHS of £14.5m.¹²

The latest indicator and most recent information from Public Health England - Percentage of adults (aged 18+) classified as overweight or obese - places St. Helens as 2nd out of 152 county & unitary authorities in England, and the highest percentage amongst all of the North West’s authorities.

5.1.1 Key Statistics

Figure 24. Percentage of adults (aged 18+) classified as overweight or obese, 2015/16



Source: Public Health England (based on Active Lives survey, Sport England), 2017

⁷ Swedish Obese Subjects (SOS) An Intervention Study of Obesity 1993

⁸ Tackling Obesity in England. National Audit Office 2001

⁹ Harvard School of Public Health <http://www.hsph.harvard.edu/obesity-prevention-source/obesity-consequences/health-effects/>

¹⁰ Circulation Journal 2006 Obesity and Cardiovascular Disease

¹¹ HSCIC 2014 <http://www.hscic.gov.uk/catalogue/PUB16077>

¹² Public Health England and National Audit office

Figure 24 shows the proportion of adults aged 18+ who are classified as overweight or obese, with a comparison to some neighbouring authorities in the North West region, demonstrating the extent of the issue in the Borough.

The 72.1% classed as overweight or obese would correspond to an estimated 101,000 people in the Borough.

5.1.2 Severe Child Obesity

According to NCMP (National Child Measurement Programme) severe child obesity (children above the 99.6th percentile) afflicts 2.5% of Reception children and 6% of Year 6 children in St. Helens (2016-17). In comparison to national figures the prevalence in St. Helens is higher than the national average for both Reception and Year 6 (2.1% and 4.4% respectively).

The UK90 growth reference is used to measure childhood weight because in children BMI changes substantially with age, rising steeply in infancy, falling during the preschool years and then rising again into adulthood. For this reason, child BMI needs to be assessed using age related curves. Whereas Adult BMI increases slowly with age, so age independent cut offs can be used to grade obesity.

If we assume those at or above the 99.6th percentile stay on the curve and multiply this by the St. Helens population (aged 11-17) we can see how many children this would correspond to in St. Helens. The estimated 11-17 population of St. Helens (2016) is 13,487, this multiplied by 0.06 (6% of Year 6 pupils in St. Helens 2016-17) we can assume that 809 children (11-17) would be on or above the 99.6th percentile in St. Helens.

5.2 Physical activity

The Department of Health strongly stresses the importance of physical activity and refer to physical inactivity as a 'silent killer'. Physical inactivity is the fourth leading risk factor for global mortality, accounting for 6% of deaths.¹³ The risk of premature death amongst physically active adults is reduced by 30%, and the risk of developing major long-term conditions such as coronary heart disease (CHD), stroke, diabetes and some cancers are reduced by up to 40%.¹⁴

5.2.1 Key Statistics

There is growing evidence of the risks of excessive sedentary behaviour (for example, watching TV and computer use) across all age groups, suggesting a link between sedentary behaviour and overweight and obesity.

According to the Active Lives Survey, 25.6% of the adult population in the UK is not active at levels to benefit their health.¹⁵ Approximately 29.3% of adults in St. Helens do not meet physical activity recommendations, doing less than 30 minutes of moderate intensity activity per week. It is important to highlight that individuals tend to overestimate the amount of activity undertaken in self-report surveys.

¹³ WHO, 2010

¹⁴ Start Active, Stay Active: Report on Physical Activity for Health from the 4 home countries - Chief Medical Officers, 2011

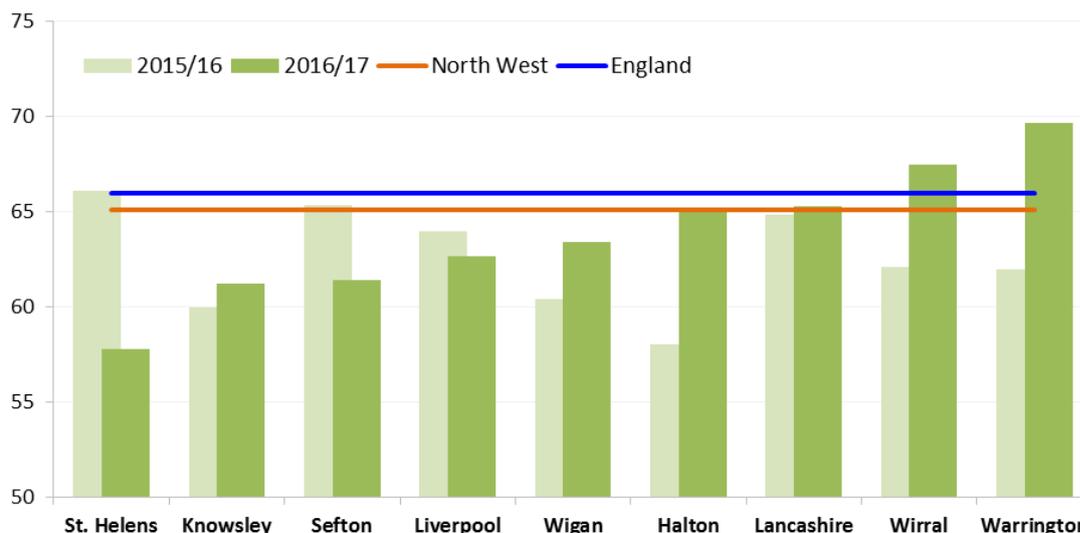
¹⁵ <https://www.sportengland.org/media/12458/active-lives-adult-may-16-17-report.pdf> data tables at LA level available, for 16+ and excludes gardening. The new PHOF indicator states age 19+ and includes gardening.

There is a continuous increase in the number of over 65 year olds in St.Helens, and a need to consider varying sports offers for this age group. The 65+ population is forecast to increase by 34% (+12,700) between 2018 and 2038 with that age group to be 26.6% of the total by 2038.

5.2.2 Physical Activity Guidelines

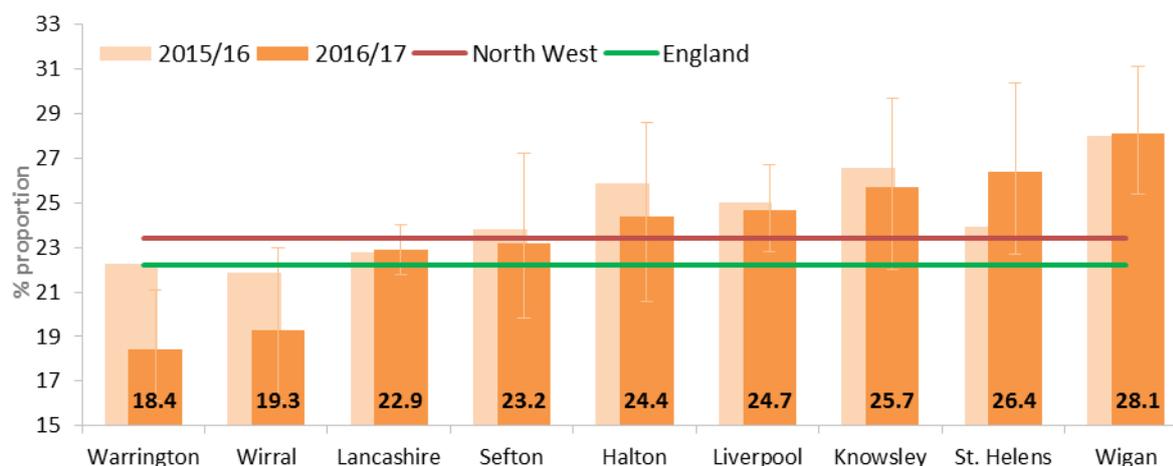
Adults aged from 19 to 64 years should aim to be active on a daily basis; over a week their activity should amount to at least 150 minutes of moderate intensity activity.

Figure 25. Percentage of adults (aged 19+) that meet CMO recommendations for physical activity (150+ moderate intensity equivalent minutes per week)



Source: Public Health England (based on Active Lives, Sport England)

Figure 26. Percentage of adults (aged 19+) that are physically inactive (<30 moderate intensity equivalent minutes per week)

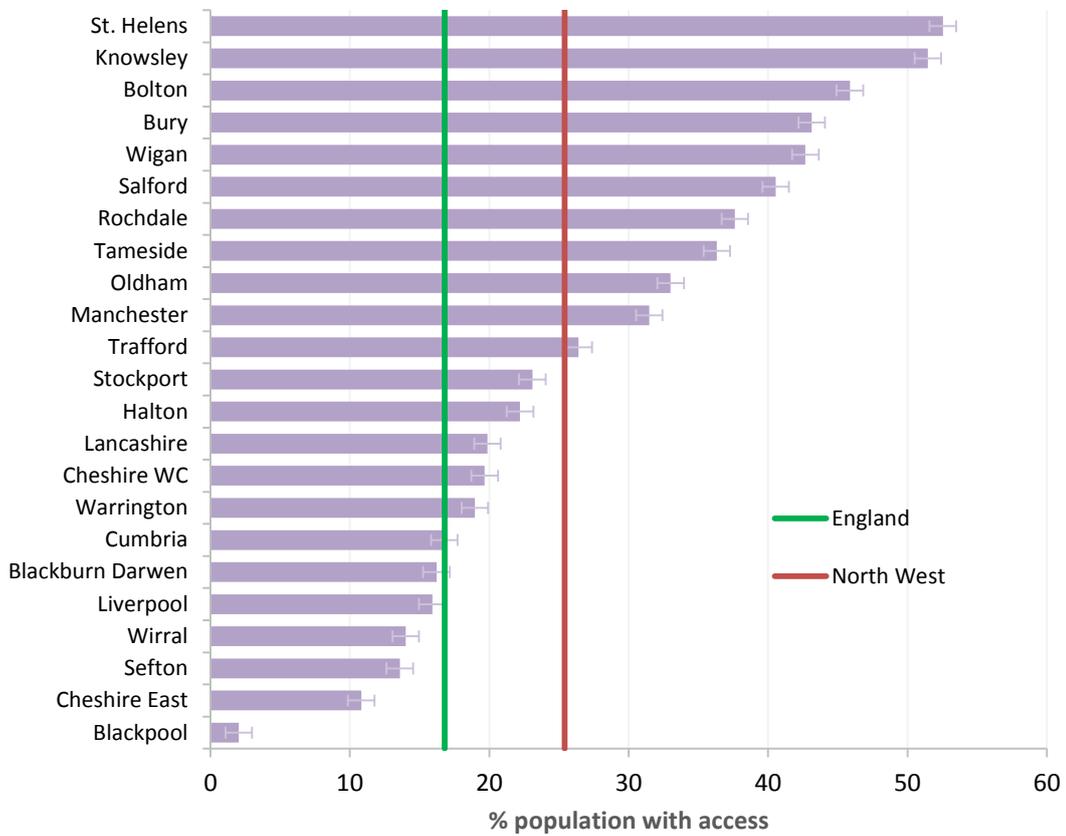


Source: Public Health England (based on Active Lives, Sport England)

It should be noted that not all physical activity is supported by formal facilities; walking, cycling and running simply requires access to open space or safe routes. Access to green space such as woodland, supports wellbeing and allows people to engage in physical activity. Both the presence of a woodland and the number of people who can readily access the space represents a significant asset to that community. Woodlands provide spaces for community activities, social connectedness,

volunteering as well as employment. Various studies report that people are more likely to make use of woodland if they are closer to home (Ward-Thompson 2004). St.Helens has the highest proportion of the population with nearby access to woodland in the North West of England.

Figure 27. % with Accessible Woodland of 2 hectare within 500m of where they live, 2015

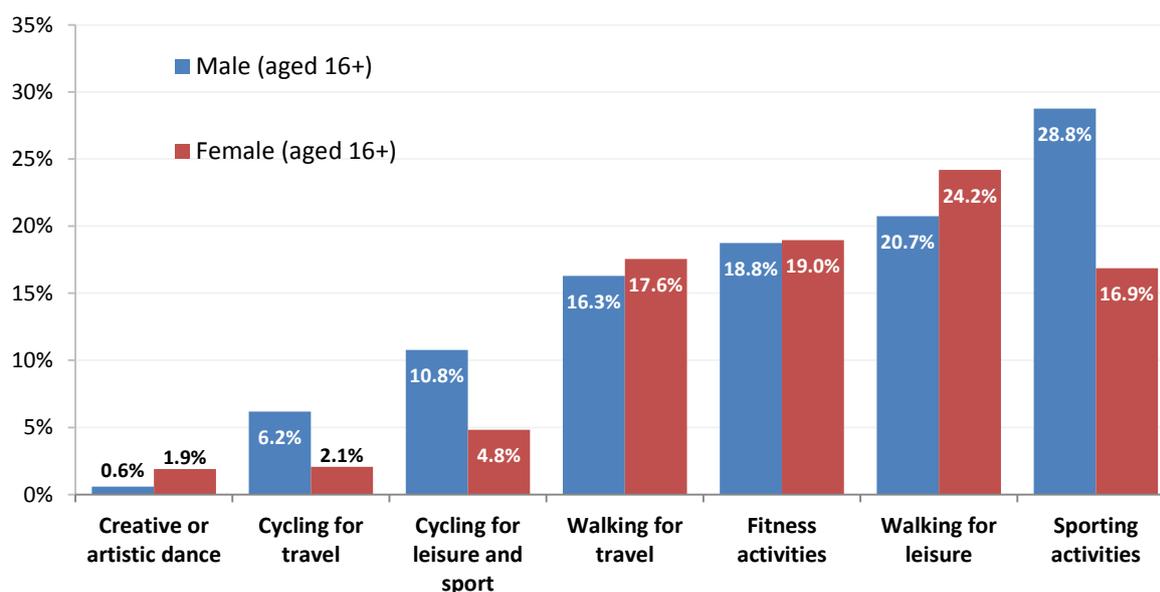


Source: Public Health England. Woodland trust: Woodland Indicators by local authority

5.2.4 Gender

Previous indicators had revealed a stark gender contrast with males more likely to participate in weekly physical activity than females. Male participation in 2016/17 has been observed to be approximately 5% higher than females. The gender gap is more pronounced for sporting activities and cycling, whereas women are more likely than men to walk for leisure or travel, or take part in fitness activities. The latest figures for gender using current methodology are only available at national level (from Public Health England/Sport England Active Lives), however the figures for ‘all persons’ in St. Helens are almost in-line with the national picture, so the broad activity categories and the gender split between could be a reasonable reflection of a local picture.

Figure 28. Taken part at least twice in the last 28 days (age 16+) 2016/17



Source: Sport England Active Lives Survey

5.2.5 Open Space Sport and Recreation Assessment

The Open Space Sport and Recreation Assessment OSSRA report gives emerging recommendations in relation to activity, playing, sports and open space infrastructure within St.Helens. It informs those in Leisure, Sport and Planning if current provision meets the needs of the local population, if it is to a good standard of quality and if there are any areas for improvement.

St.Helens has a wide variety of playing and sports related facilities and pitches catering for activities such as rugby and hockey to swimming and bowls. Many of these pitches have clubs and additional facilities such as changing rooms, and the report encourages increased use of these additional facilities by the community, particularly at the pitches that are currently underutilised. It also highlighted the importance of making links with local schools to allow community groups access to pitches and sports halls available on sites within the primary and secondary schools.

Pitches and sports facilities are well used in St.Helens, however the report found that usage amongst young people, juniors and girls/women should be increased.

In St.Helens there is also an unmet need for swimming. The need could be addressed by widening community access to current provision.

The report also indicates that membership/participation figures of council leisure facilities in the south of the Borough are very low.

The report found that St.Helens Council managed facilities are all above average or good in quality and are strategically placed in the Borough to enable good access to a large proportion of the main population.

The latest full report can be viewed online - https://www.sthelens.gov.uk/media/5179/st-helens-open-space-assessment-report-june-2016_final-web.pdf

6. Substance Misuse

Drugs have a profound and negative effect on communities, families and individuals, from the crime in local neighbourhoods, through families forced apart by drug dependency, to the corrupting effect of international organised crime.

Information about the number of people who use drugs, specifically illicit drugs is key to formulating effective policies and helping to inform service provision at a local level for tackling drug related harm. Drugs such as heroin, opiates or crack cocaine are associated with the highest levels of harm and people who use these drugs are described as opiate and/or crack cocaine users (OCUs). It also helps inform commissioning of service provision at a local level and provides a context in which to understand the population impact of interventions to reduce drug-related harm.

6.1 Key Statistics

The latest available 'Glasgow prevalence estimation' figures (based on 2014/15 data), indicates that St.Helens had a 15-64 population of 112,309 and has an estimated total of 1,386 OCUs.

Table 1. Local substance misuse prevalence

	Estimated Number of Users (St.Helens)		Rate per thousand of the population (St.Helens)		Rate per thousand of the population (North West)		Rate per thousand of the population (England)	
	2011/12	2014/15	2011/12	2014/15	2011/12	2014/15	2011/12	2014/15
OCUs	1,232	1,386	10.83	12.34	9.99	10.63	9.07	8.57
Opiate	1,154	1,138	10.14	10.13	8.4	9.29	7.32	7.33
Crack	600	704	5.27	6.27	-	6.25	-	5.21

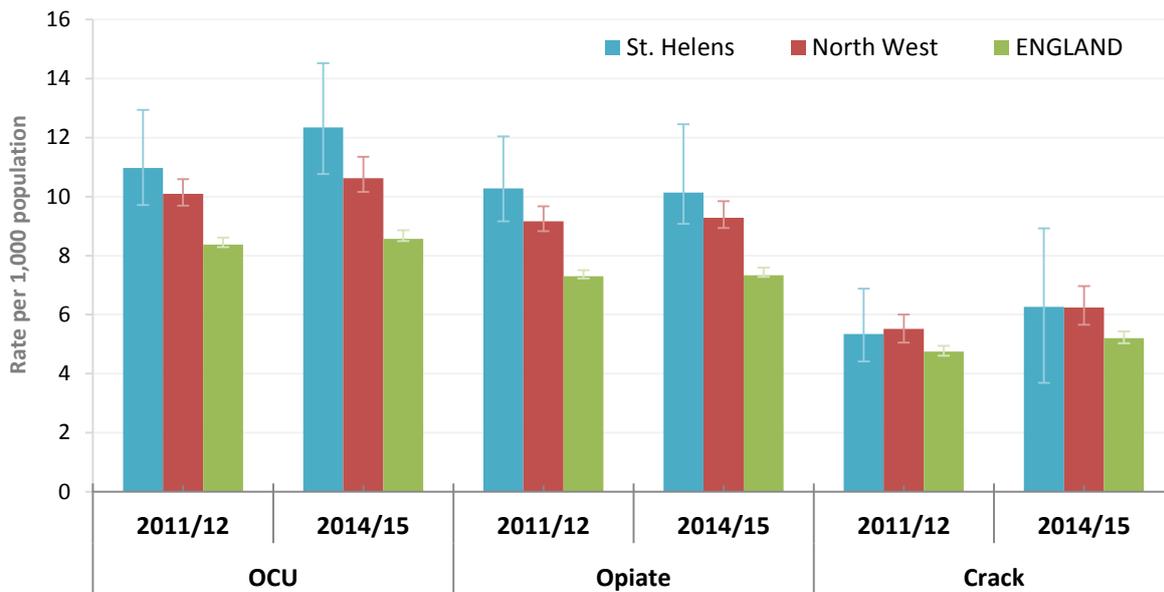
Source: Glasgow Prevalence Estimation

* 'OCU' refers to use of opiates and/or crack cocaine, including those who inject either of these drugs. It does not include the use of cocaine in a powder form, amphetamine, ecstasy or cannabis, or injecting by people who do not use opiates or crack cocaine. Although many opiate and/or crack users also use these drugs it is very difficult to identify exclusive users of these drugs from the available data sources.

- data not available

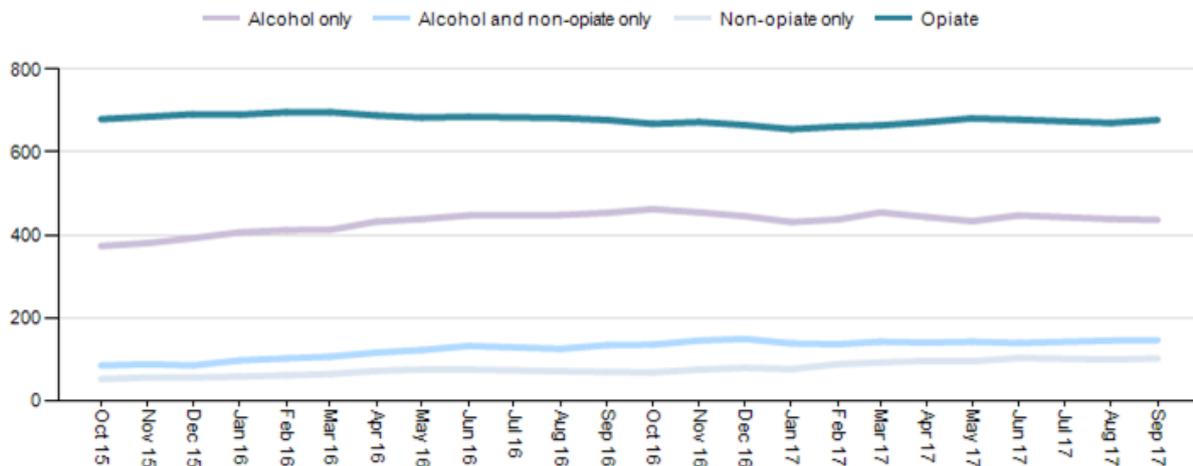
There are no significant increases for St.Helens in comparison to previous years, or significant differences compared to regional and national prevalence estimates.

Figure 29. Substance misuse prevalence trend - Local Authority, Regional, National



The chart below illustrates the trends in the number of clients accessing specialist structured community based treatment. Based on a 12 month rolling period, at the end of 2015/16 there were a total of 1276 individuals that had received structured drug treatment.

Figure 30. Number of clients accessing specialist structured community based treatment



Source: NDTMS Adult Activity Reports Partnership

Local annual performance of successful completions as a proportion of all in treatment ranged between 5.6% - 8.8% for opiates and 41.8% - 65.8% for non-opiates. By the end of Quarter 2 in 2017/18 the proportions had dropped slightly with 5.0% for opiates and 32.4% for non-opiates.

The proportion of opiate and non-opiate clients in treatment, who successfully completed treatment and did not represent within six months was 19.1%, which was significantly higher than the annual

local target of 13%. The annual local target for 2017/18 had been raised to 14.2% and the result at the end of Quarter 2 was still above the target at 15.6%.¹⁶

6.2 Injecting and Harm Reduction:

The current OCU injecting estimate available via PHE/Glasgow prevalence estimate indicates that there are approximately 280 OCU injectors in St.Helens. However, in 2015/16, out of 723 new treatment journeys, only 51 clients during this time stated that they were currently injecting, local intelligence supports the view that this number is vastly under reported, and that many clients will not declare to their key worker that they are currently injecting.

Further work with the community provider, locally commissioned pharmacies and clients accessing treatment needs to be done to fully understand the true extent of injecting behaviour. In particular, there needs to be increased reporting and recording of a client's primary substance when registering/accessing the needle exchanges.

Needle and Syringe Programmes (NSPs) are currently commissioned for people over the age of 18 years who inject illicit substances and non-prescribed anabolic steroids (including other performance and image-enhancing drugs which may be injected). It is a confidential service that provides the necessary level of privacy to clients, it provides people who inject drugs with (free) needles and syringes and other equipment used to prepare and take illicit drugs; it also provides a safe route of disposal for used equipment.

In 2015/16 there were a total of 15,287 transactions taking place at St.Helens NSPs (pharmacy and specialist data combined). 87.6% of those attending an NSP in 2015/16 were male. Those aged between 35-44 years make up the largest proportion that accessed NSP services in 2015/16 (38.5%). CGL (specialist treatment provider) is also commissioned to deliver a NSP service. This is a targeted 'Pick and Mix' confidential service that provides the necessary level of privacy to people who inject drugs, it provides people with (free) needles and syringes and other equipment used to prepare and take illicit drugs and it also provides a safe route of disposal for used equipment. The 'Pick and Mix' service involves the distribution of bespoke/ loose injecting equipment plus health promotion advice.

6.3 Addiction to Medicines

As well as harm from the use of opiate and crack cocaine, there are wider trends such as over the counter (OTC) and prescription only medication (POM) and new psychoactive substances that may be having an impact on local communities. This is an area in which further research is needed to improve the knowledge in the UK as to the prevalence of need, key challenges, priorities and also strategic response.

Addiction to medicines (ATM) is costly to individuals and the health care system, especially when there are limited tailored prevention and treatment interventions available and accessible to those who need them. Research with local community pharmacies and GPs was conducted across Cheshire

¹⁶ Statistic sources: NDTMS *Adult Activity Reports-Partnership*, NDTMS *Qtr 4 DOMES*, CGL *Local Data*

and Merseyside by Liverpool John Moores University regarding addictions to medicines in 2015, to establish the extent and nature of the problem.¹⁷

Key findings included:

- A large majority of participants (92%) agreed that addiction to medicine is an important health issue.
- Participants indicated that they frequently suspected addiction with two thirds (66%) reporting that they suspect a patient is developing an addiction to prescription only medicines, and nearly half (46%) suspecting addiction to medicines purchased over the counter, on a weekly or more frequent basis.
- It was identified that patients were most frequently developing addictions on anxiolytics and hypnotics, as well as both strong and weak opioid analgesics. Less frequently identified but still encountered addictions were drugs including anti-epileptics and neuropathic analgesics, sedating antihistamines, antitussives and stimulants.

¹⁷ The extent and nature of addiction to medicines in Cheshire and Merseyside, LJMU, 2015

7. Sexual Health

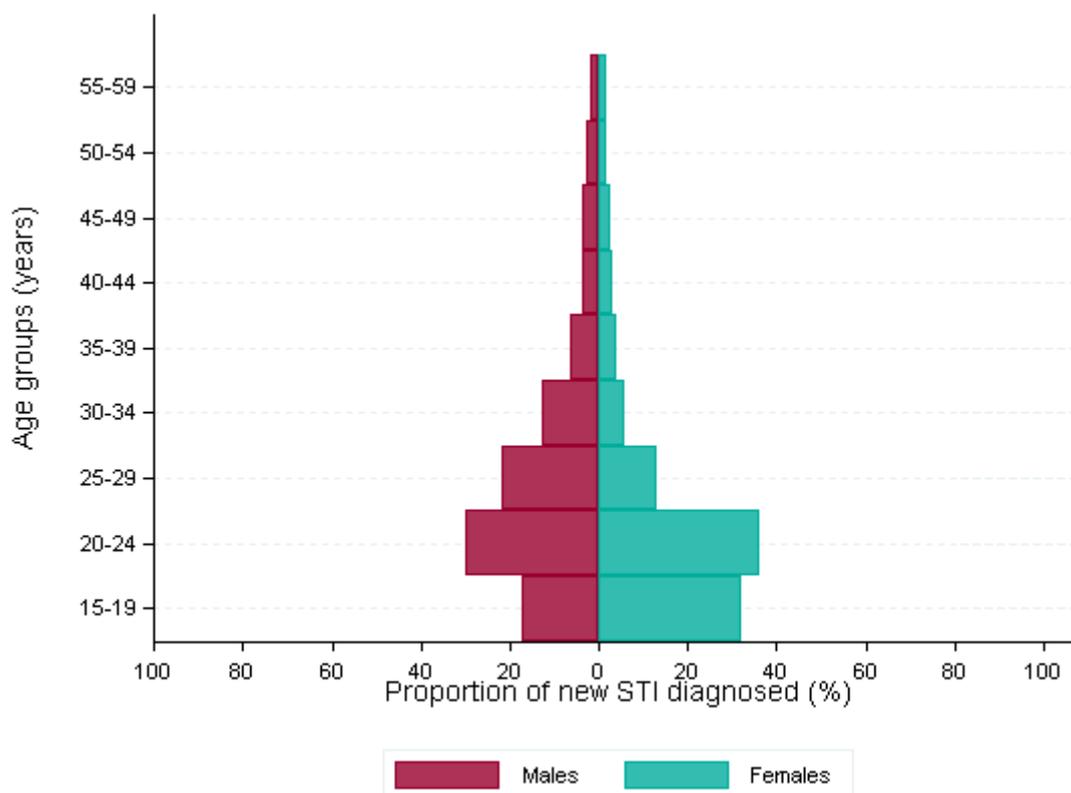
Improving the sexual health of the population can be complex. It requires measures to prevent and reduce incidences of sexually transmitted infections (STIs) and physical ill health as a result of those infections. In addition, there is the need to ensure that people, whatever their age, have the right information and support to assist them in making informed choices about relationships and sex, that they have choices about creating a family at a time that is right for them and that they stay emotionally healthy and free of discrimination.

7.1 Sexually Transmitted Infections (STIs)

Sexually transmitted infections (STIs) are diseases that can be transmitted by unprotected sex. If left undetected and untreated they may result in serious complications in later years ranging from infertility to cancer. STIs include gonorrhoea, chlamydia, herpes, syphilis and genital warts.

Young people aged between 15 and 24 years, experience high rates of new STIs. This is reflected in St. Helens where 60% of diagnoses of new STIs made in SHSs and non-specialist SHSs were in young people in this age-group.

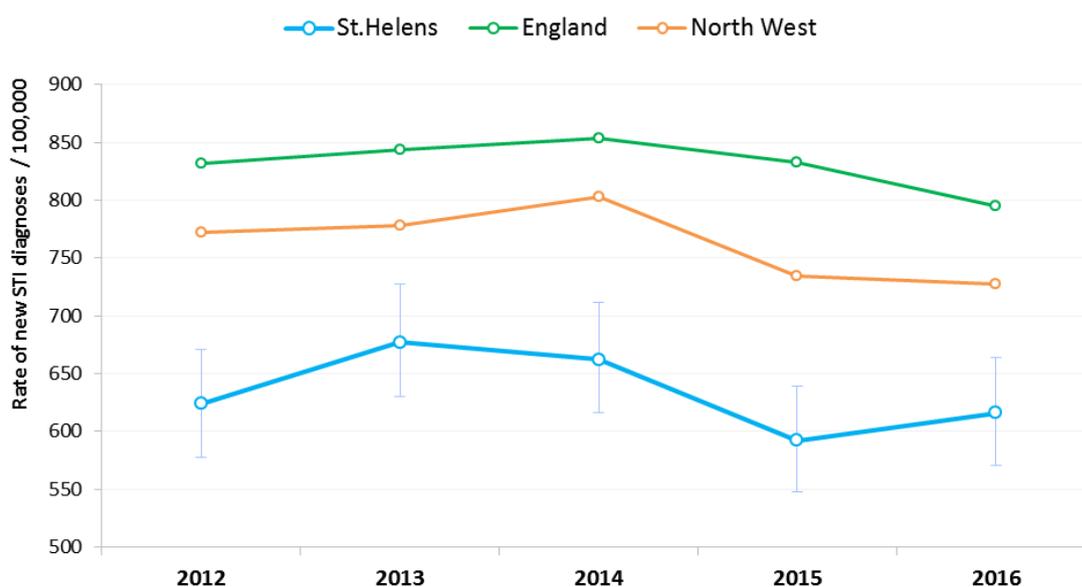
Figure 31. Proportion of new STIs by age group and gender in St. Helens



Source: Data from routine specialist and non-specialist sexual health services' returns to the GUMCAD STI Surveillance System and routine non-specialist sexual health services' returns to the CTAD Chlamydia Surveillance system (CTAD).

The latest data show new STI diagnoses in England, (excluding chlamydia in people aged under 25 years, which is specifically targeted), fell to 795 diagnoses per 100,000 people, from a high of 853 per 100,000 in 2014. This corresponds to 280,622 cases across the country. The rate of STIs diagnosed in St.Helens has stayed steady over recent years. In 2016, this was 616 diagnoses per 100,000, (691 cases).

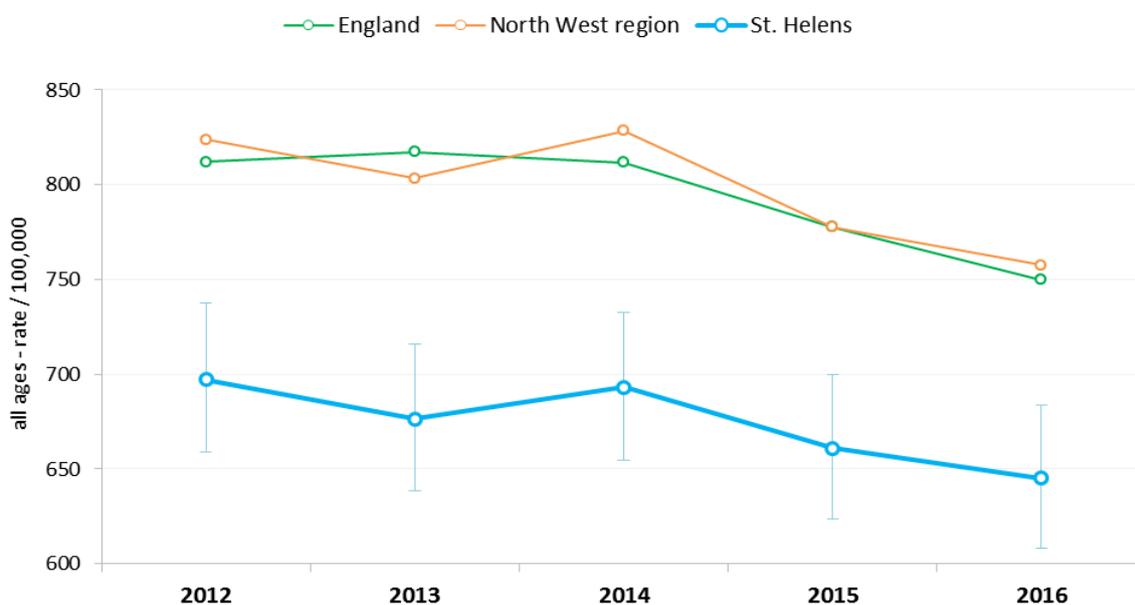
Figure 32. New STI diagnoses (exc. chlamydia in <25 year olds) per 100,000 aged 15 to 64



Source: Sexual and Reproductive Health Profiles, PHE 2017

When we look at figures including chlamydia diagnoses the St.Helens rate increases to 645 per 100,000. This corresponds to 1,146 cases and the rate is significantly lower than the national average of 750 per 100,000.

Figure 33. All new STI diagnosis rate per 100,000 population



7.1.1 Chlamydia

The National Chlamydia Screening Programme (NCSP) offers opportunistic screening of sexually active young people aged 15 to 24 years with the aim of increasing the detection of chlamydia and reducing the prevalence of associated infection. In 2016, over 1.4 million chlamydia tests were carried out in England among young people aged 15 to 24 years.

Those aged under-25 experienced the highest STI rates, contributing 62% of chlamydia diagnosed in this age group’s heterosexuals in 2016. Compared to people aged 25 to 59 years, rates of STI diagnoses in this age-group are twice as high in men and seven times as high in women.

The number of new cases of chlamydia detected in St.Helens was 437 in 2016, a decrease of 14% since 2012. In 2016 the detection rate per 100,000 aged 15-24 years (2,144) was lower than the North West region (2,247) but higher than the England rate (1,882).

Figure 34. Rate of chlamydia detection per 100,000 aged 15 to 24 - Trend 2012 - 2016

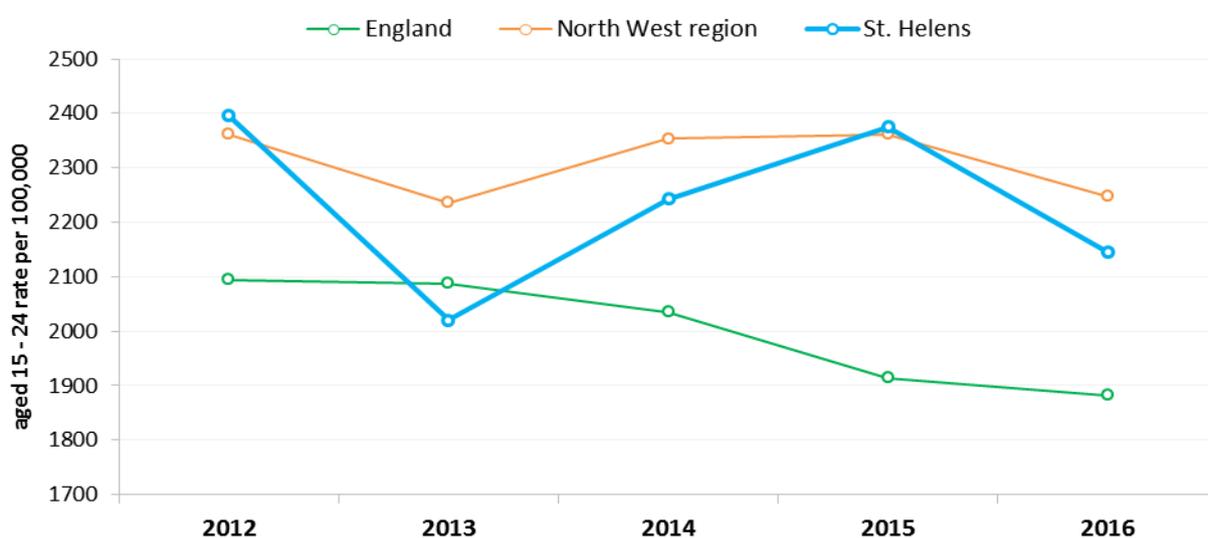


Figure 35. Chlamydia detection rate / 100,000 aged 15-24 - Gender

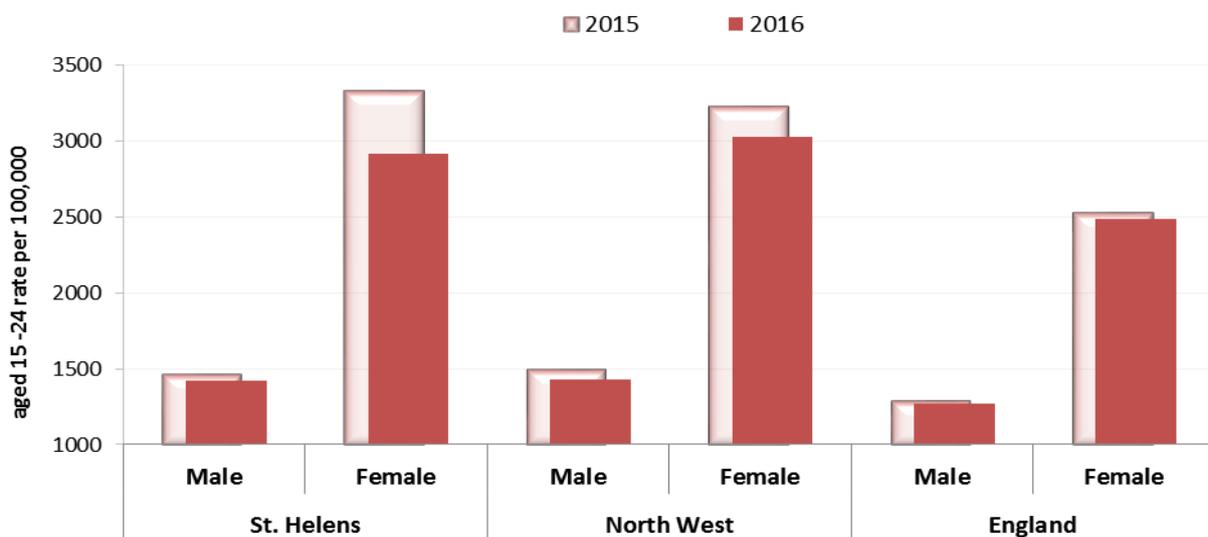


Figure 36. Proportion of population aged 15 to 24 screened for chlamydia in specialist, non-specialist sexual health services - 2012 - 2016

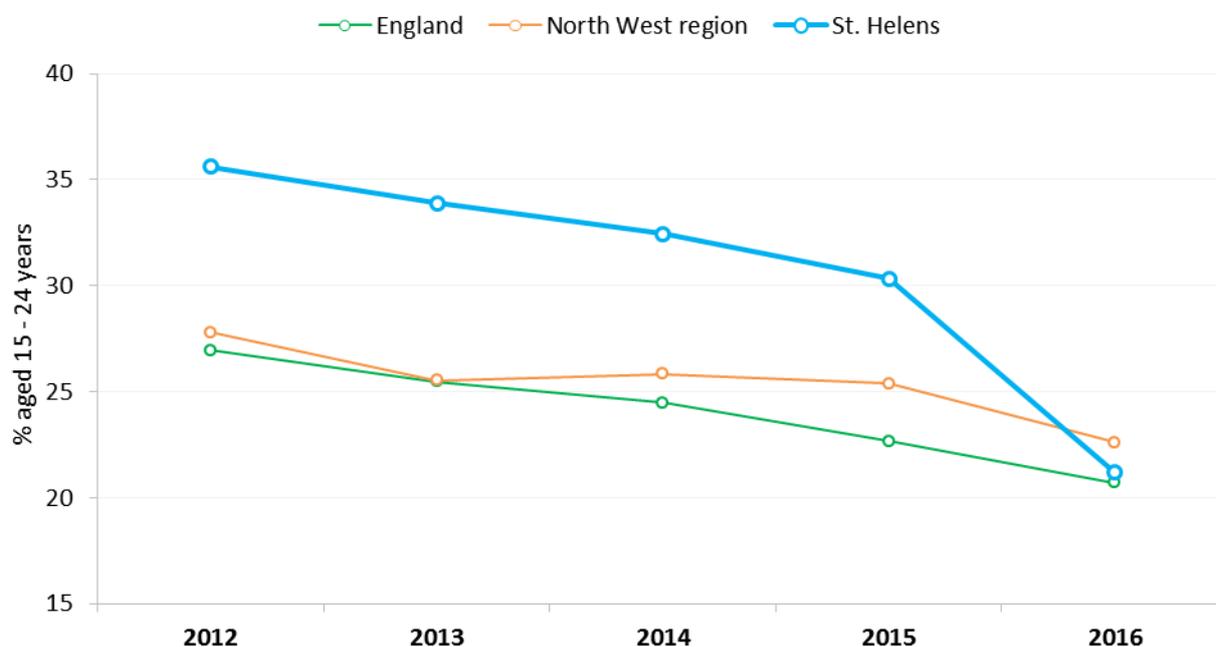
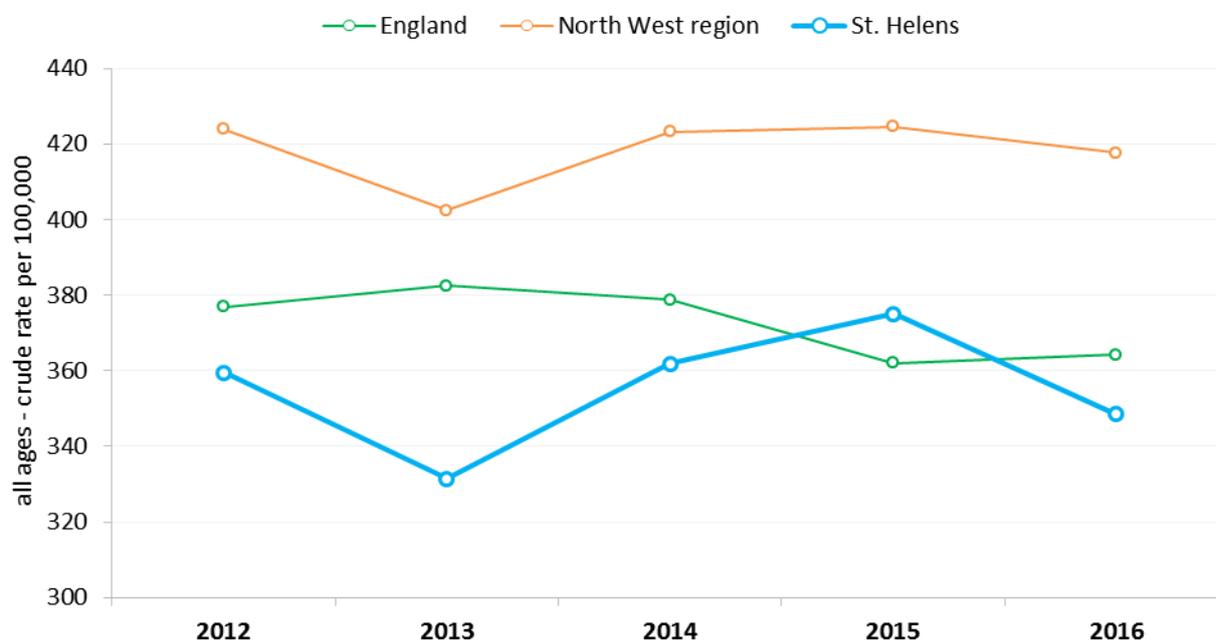


Figure 37. Rate of chlamydia diagnoses per 100,000 population - Trend 2012 - 2016



In 2016 the chlamydia diagnostic rate in St. Helens was 349 per 100,000 for all ages, lower than both regional and national rates. The rate for St. Helens drops even further when looking at women and men aged 25 years and over, to 134 per 100,000, compared to regional and national rates which are the same rate at 188 per 100,000.

7.1.2 Gonorrhoea

Between 2015 and 2016, new gonorrhoea diagnoses across England decreased by 10.6% overall (from 39,985 to 35,728), and decreased 22% in the MSM population (from 22,419 to 17,584). This is the first decrease since 2008. Between 2012 and 2015 the overall diagnoses increased by 54% (from 25,969 to 39,985). Despite the decrease in gonorrhoea diagnoses between 2015 and 2016, sustained transmission is of concern as the global threat of antibiotic resistance grows.¹⁸

Between 2012 and 2016, the number of cases of gonorrhoea diagnosed in St.Helens increased by 81%, with 76 cases in 2016. However, the rate of gonorrhoea infections from St. Helens was lower than the North West region and England in 2016.

Figure 38. Number of cases of Gonorrhoea in St.Helens between 2012 and 2016

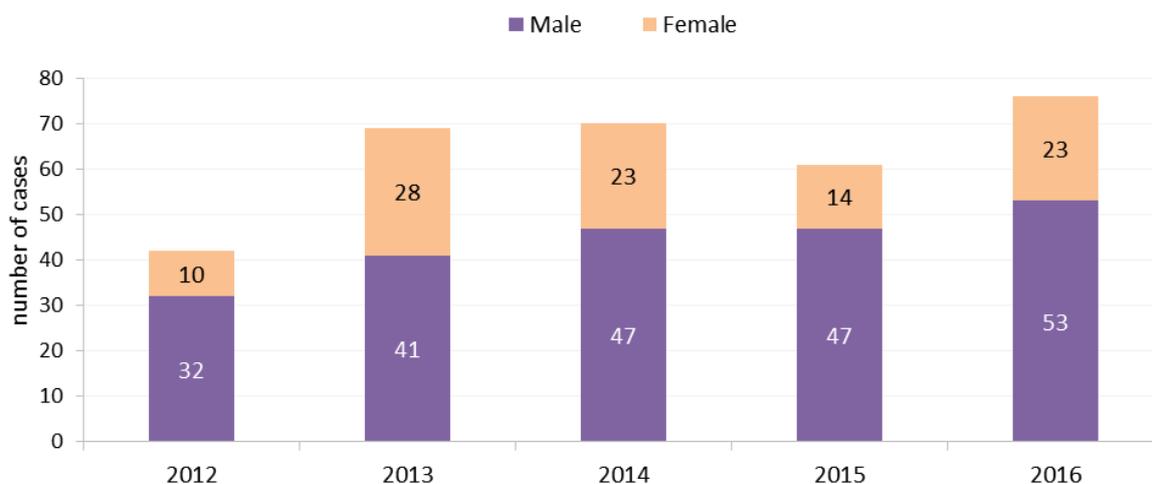
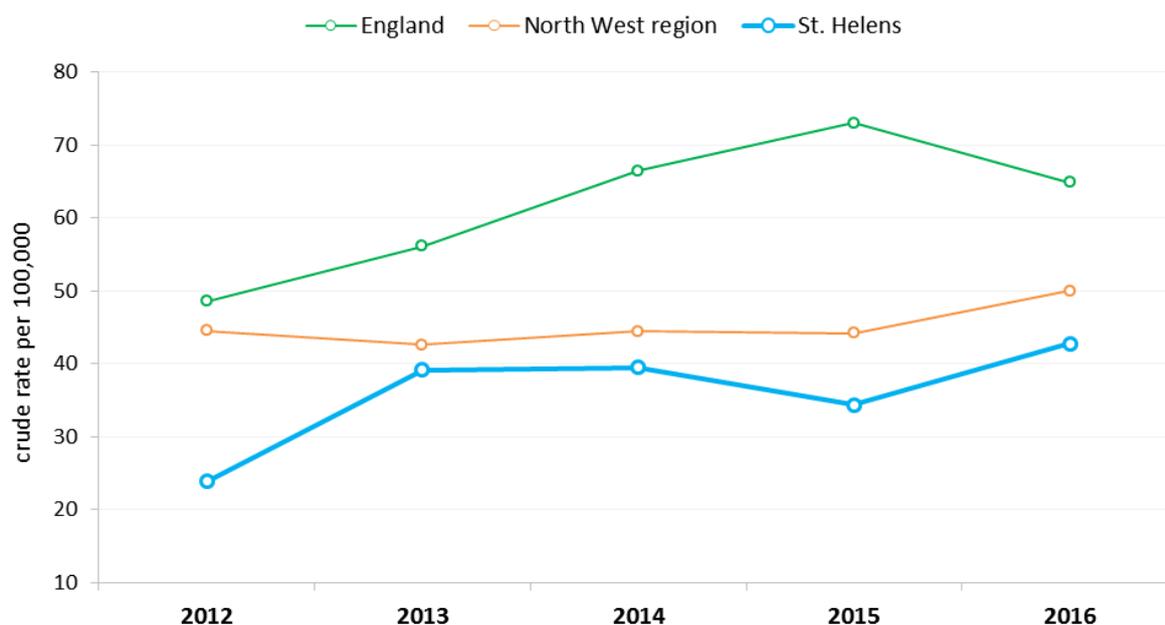


Figure 39. Rate of Gonorrhoea diagnoses per 100,000 population

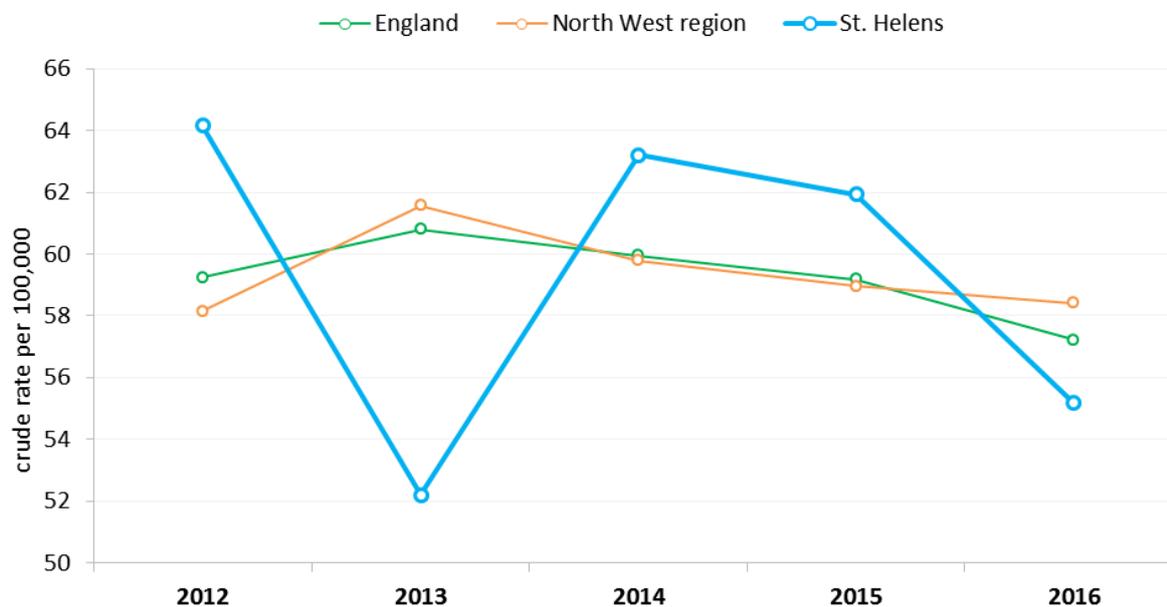


¹⁸ <https://www.gov.uk/government/publications/gonococcal-resistance-to-antimicrobials-surveillance-programme-grasp-report>

7.1.3 Herpes, Syphilis and Genital Warts

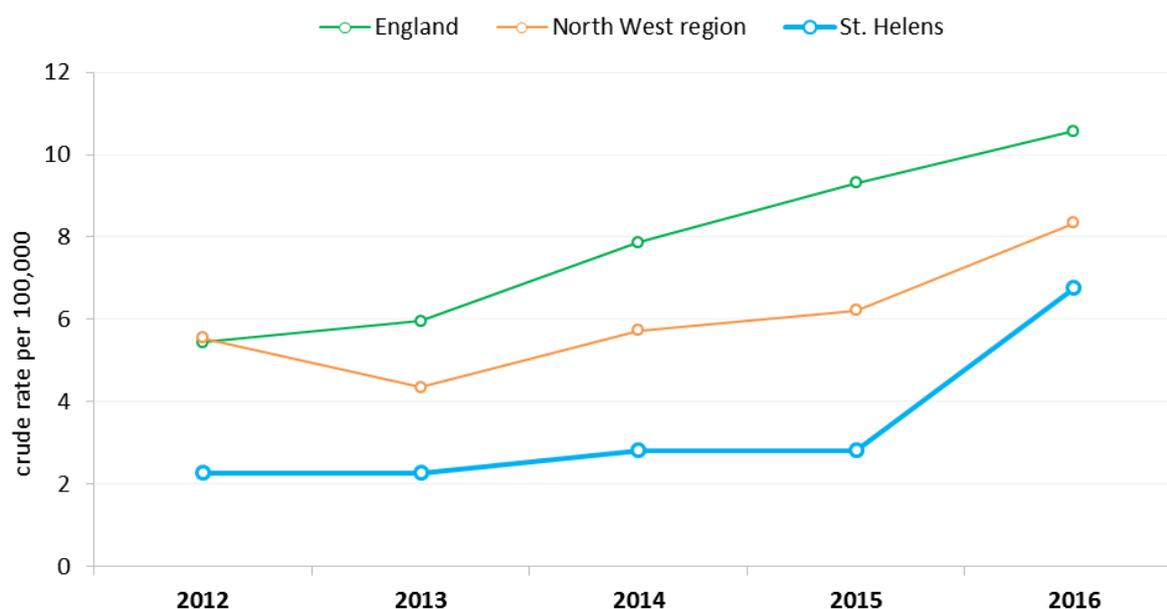
The number of cases of newly diagnosed herpes in St.Helens was 98 in 2016, a decrease of 13% since 2012. The rate of herpes infections was lower than both the North West region and England in 2016.

Figure 40. Genital herpes diagnosis rate per 100,000



The rate of syphilis infections has increased slightly in recent years but is still lower than both the North West region and England. The number of cases in St.Helens increased, from 4 in 2012 to 12 in 2016.

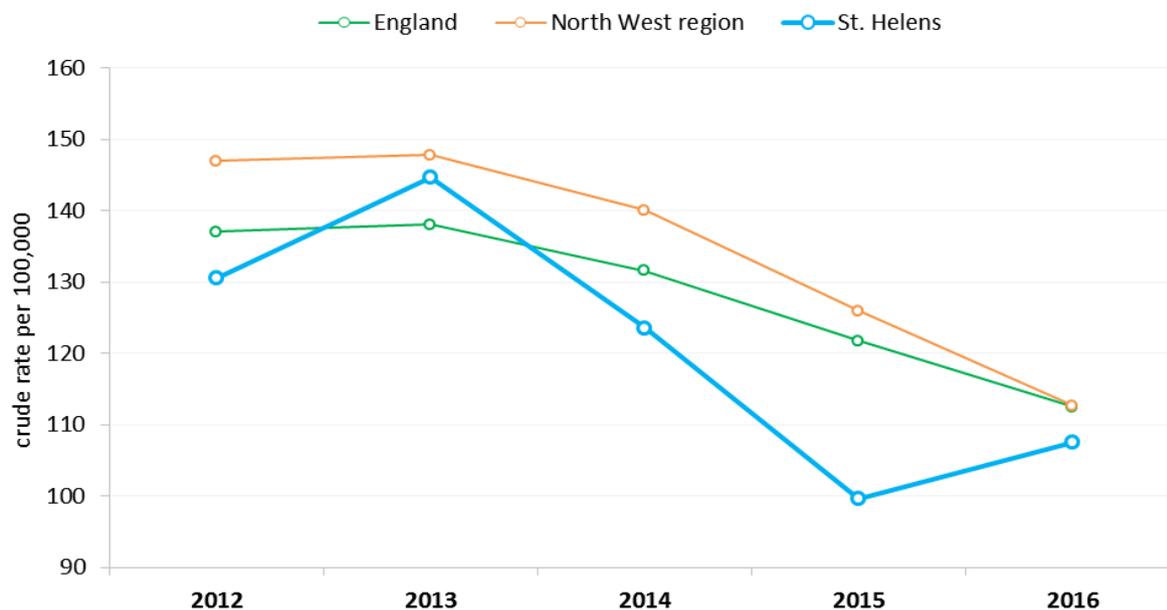
Figure 41. Syphilis diagnostic rate per 100,000



The number of cases of genital warts in St.Helens has decreased by 17% since 2012. In 2016, there were 191 cases diagnosed. This rate was lower than the North West region and England in 2016.

However, the rate for St. Helens increased from 2015 to 2016, whereas regional and national figures have seen a steady downturn since 2013.

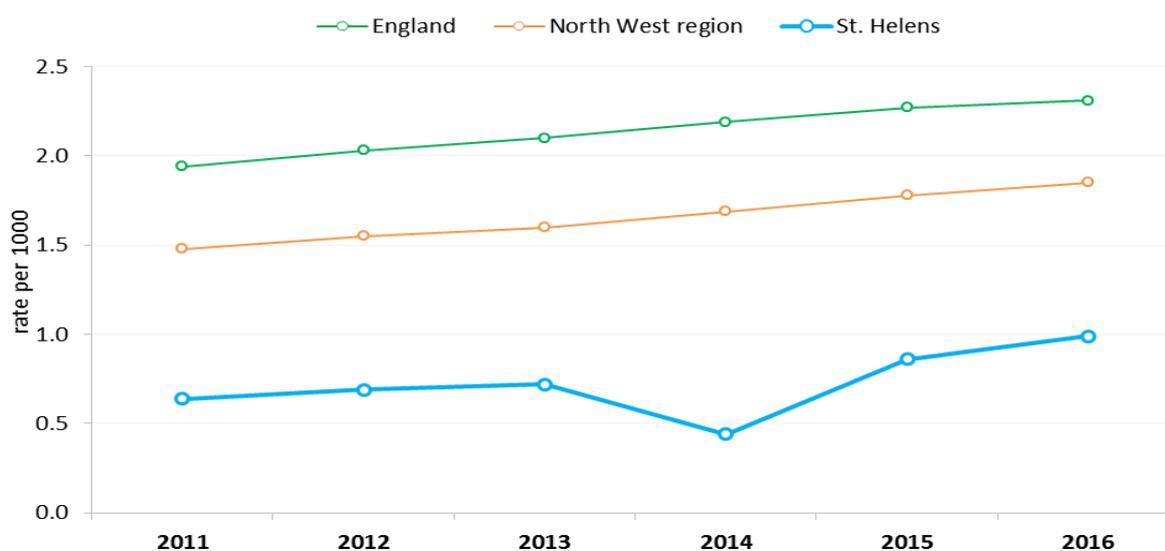
Figure 42. Genital warts diagnostic rate per 100,000



7.2 HIV

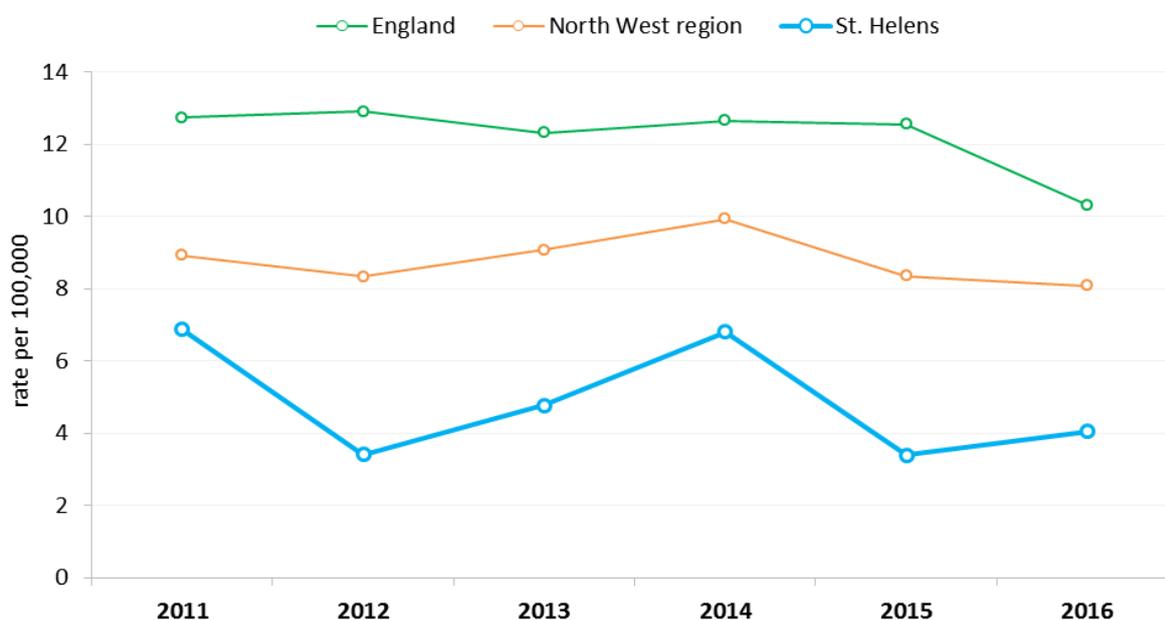
According to Public Health England, the overall prevalence of HIV infection in St. Helens in 2016 is 0.99 per 1,000 15-59 year olds, which corresponds to 101 people. This rate is significantly lower than the national average (2.31 per 1,000) and lower than Liverpool and Manchester (2.1 and 6.5 per 1,000 respectively). The St.Helens rate is similar to the neighbouring boroughs of Knowsley (0.8), Halton (0.9) and Warrington (0.97) and there were 6 new cases of HIV/AIDS diagnosed in St.Helens in 2016.¹⁹

¹⁹ PHE Sexual and Reproductive Health Profiles 2017 <https://fingertips.phe.org.uk/profile/sexualhealth>

Figure 43. HIV diagnosed prevalence rate per 1,000 aged 15-59

Source: PHE Sexual and Reproductive Health Profiles 2017

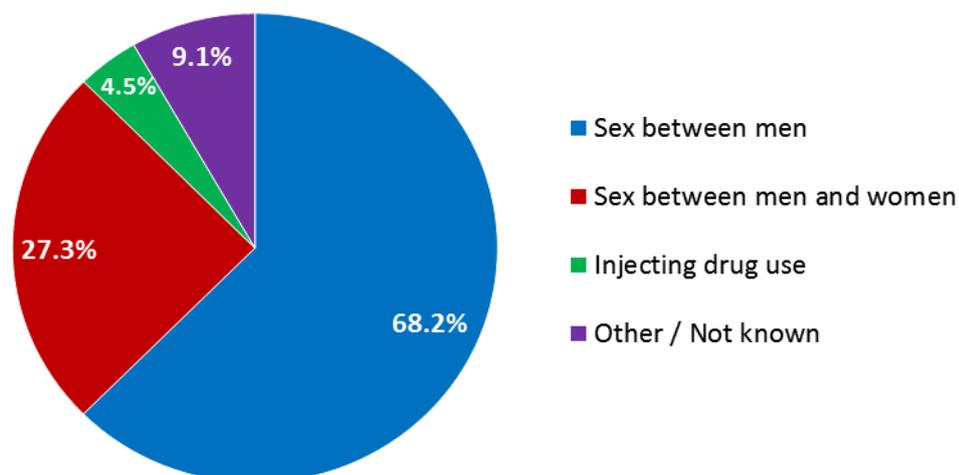
The diagnosed HIV prevalence was 1.0 per 1,000 population aged 15-59 years (compared to 2.3 per 1,000 in England).

Figure 44. New HIV diagnosis rate per 100,000 aged 15+

Source: PHE Sexual and Reproductive Health Profiles 2017

There were 6 new HIV diagnoses in individuals aged 15 years and above in St. Helens. The rate of new diagnoses is less than half of that England overall (4.3 and 10.1 per 100,000).

Figure 45. Probable infection routes for HIV in St.Helens (2016)

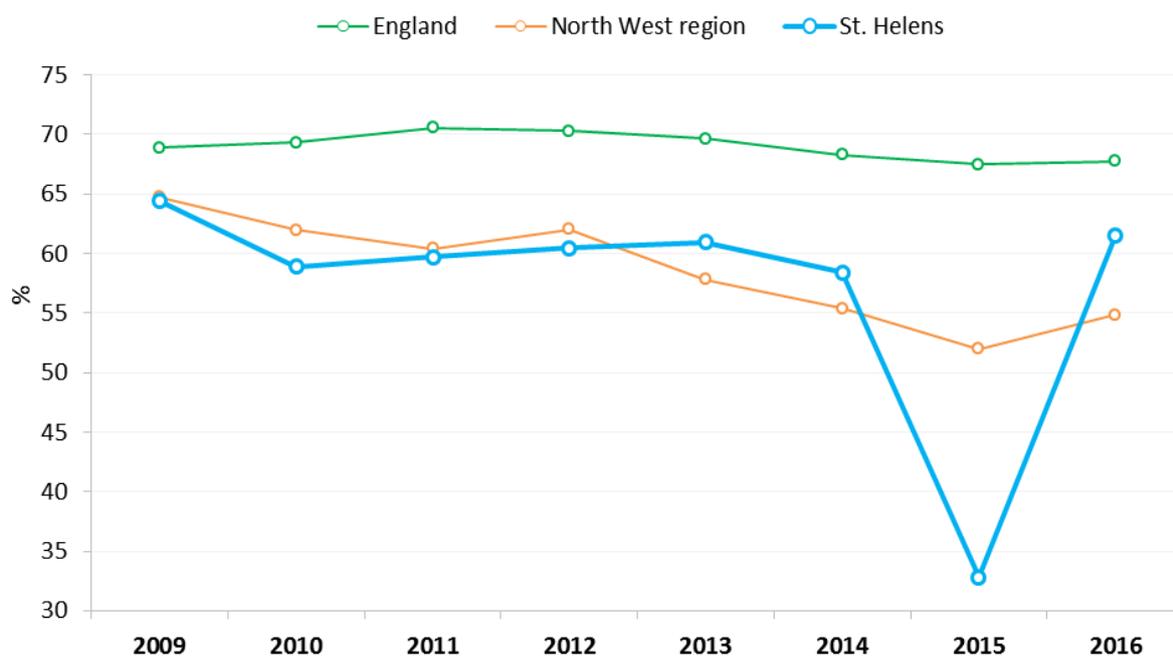


Source: HIV and AIDS Reporting System (HARS) (Please note figures are rounded to prevent data disclosure)

In 2016, 110 residents in St. Helens received HIV-related care: 100 (number rounded up to nearest 5) males and 15 (number rounded up to nearest 5) females. This represents a 47% change from 2012 to 2016. Among these, 91% were white, and 9% black African. With regards to exposure, 68% were recorded as probably acquiring their infection through sex between men and 27% through sex between men and women.

The coverage of HIV testing in sexual health services was lower than the national average (61.5% versus 67.7%). 1,855 people were tested in St.Helens in 2016.

Figure 46. HIV testing coverage, total (%)



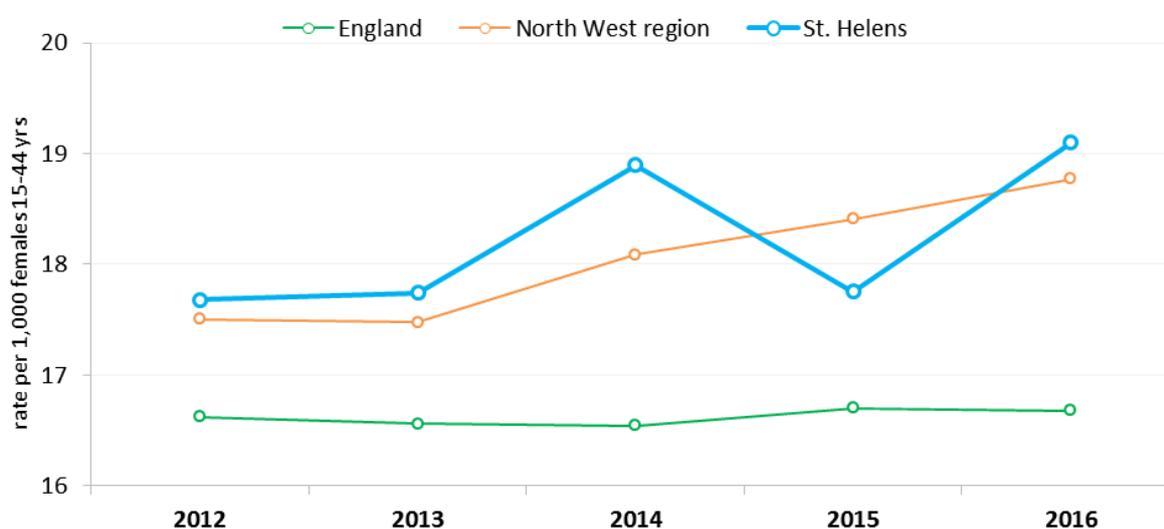
Source: PHE Sexual and Reproductive Health Profiles 2017

In St. Helens, between 2014 and 2016, 43.8% of HIV diagnoses were made at a late stage of infection (CD4 count \leq 350 cells/mm³ within 3 months of diagnosis) compared to 40.1% in England. Also, within St. Helens 50% of men who have sex with men (MSM) and 40% of heterosexuals were diagnosed late.

7.3 Abortion

The total abortion rate, under 25 years repeat abortion rate, under 25 years abortions after a birth, and over 25 years abortion rates, are indicators of lack of access to good quality contraception services and advice, as well as problems with individual use of contraceptive method.

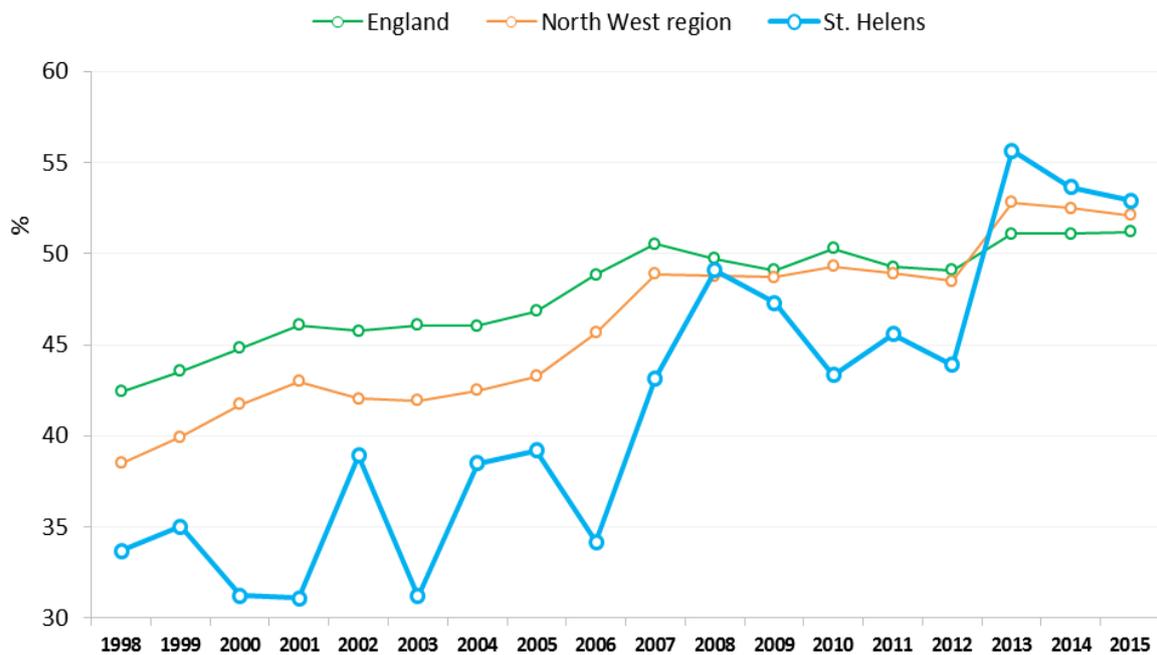
Figure 47. Rate of abortions per 1,000 female population aged 15-44 - trend



Source: PHE Sexual and Reproductive Health Profiles 2017

There were 616 abortions in St. Helens in 2016. The abortion rate for in St. Helens is 19.1 per 1,000 female population aged 15-44 years, higher than the England rate of 16.7 but almost in line with the regional rate of 18.8. The rate ranks 14th out of 23 North West local authorities and 47th out of 147 UTLA in England. The change from 2015 was 6.6%.

Figure 48. Under 18s conceptions leading to abortion (%) - trend 1998 - 2015



In 2015, the percentage of conceptions to those aged under 18 years that led to an abortion in St. Helens was 52.9%, slightly higher than regional (52.1%) and national (51.2%) rates. The rank (out of 324) within England for the under-18s conceptions leading to abortion was 166th (where 1st has the highest percentage).

7.4 Contraception

The table below describes the range of sexual and reproductive health (SRH) services provided to residents of St. Helens, North West PHE Centre and England.

Table 2. Number and proportion²⁰ of most common contraceptive and other sexual and reproductive health (SRH) services provided among residents of St. Helens

SRH service provided	St.Helens (n)	St.Helens (%)	NW PHE (%)	England (%)
Regular contraceptive care	13,485	35.4%	43.7%	43.7%
Emergency contraceptive care	1,315	3.5%	3.0%	2.9%
Pre-contraception consultation	2,395	6.3%	4.2%	5.6%
Implant removal	580	1.5%	2.8%	3.4%
IUS Removal	160	0.4%	0.9%	1.1%
IUD Removal	130	0.3%	0.7%	0.8%
Sexual health advice	15,620	41.0%	34.7%	30.2%
Pregnancy related care	2,760	7.3%	5.4%	6.7%
Abortion related care	145	0.4%	0.4%	1.0%
Cervical screening	800	2.1%	1.8%	1.4%
Psychosexual related care	60	0.2%	0.6%	0.7%
Other Referrals	570	1.5%	0.7%	0.8%
TOTAL	38,070			

Source: SRHAD. Data from Sexual and Reproductive Health Services. (Data are rounded to the nearest five cases)

In 2016, there were 13,485 attendances at sexual health services by St.Helens residents where regular contraception was prescribed. The types of contraception are split into two main groups, long acting reversible methods (LARC, such as contraceptive implants and intrauterine systems or devices), and user dependent methods (UDM, such as the oral contraceptive pill or condoms). Long acting reversible contraception methods are considered to be more effective as they typically last for three or more years and do not depend on daily adherence or correct usage by the patient. They are also considered to be more cost effective, and their increased uptake could further help to reduce unintended pregnancy.²¹

Contraceptive injections are excluded from the LARC (long-term) categorisation, due to reliance on users' compliance to turn up promptly for doses every 12 weeks. This is a short duration compared to doses lasting for 3 years, 5 years and 10 years for implants, IUS and IUD respectively.²² Consequently, the failure rate of contraceptive injections is typically higher than for the longer acting methods.

²⁰ Please note: to prevent deductive disclosure, the number of SRH services provided in St.Helens have been rounded to the nearest 5. Therefore the totals may not equal the sum of their parts. Percentages will be distorted by rounding especially where small numbers are involved.

²¹ <https://www.nice.org.uk/guidance/CG30/>

²² <https://www.nice.org.uk/guidance/cg30/chapter/Appendix-A-Features-of-the-LARC-methods-to-discuss-with-women/>

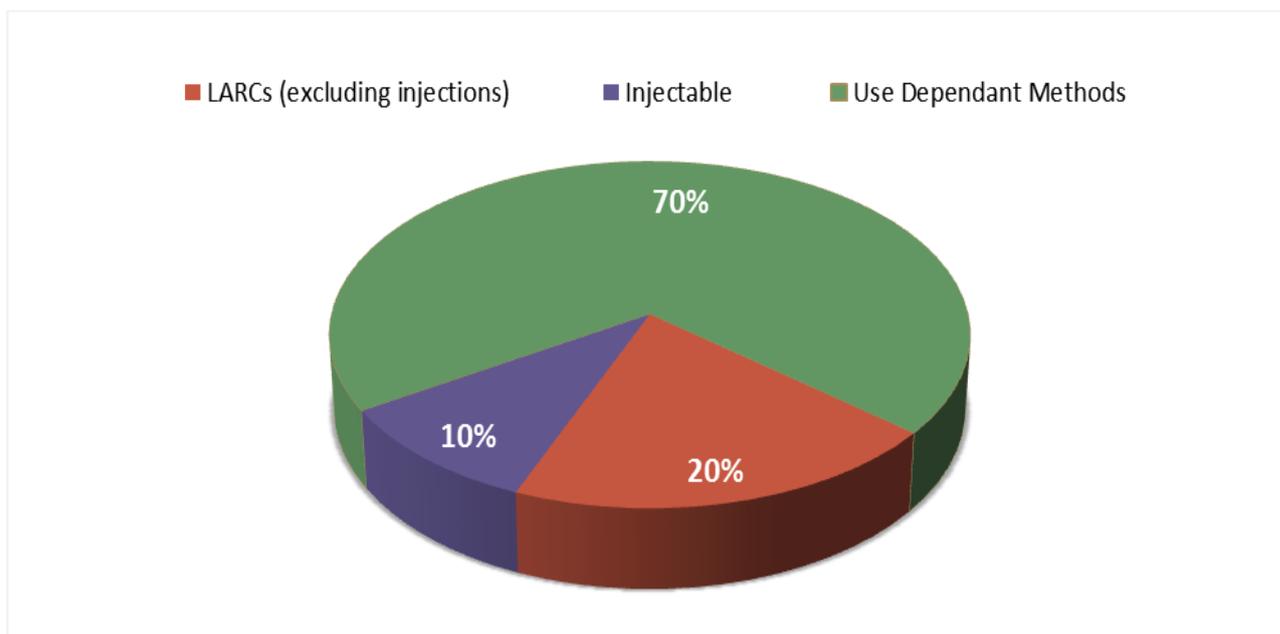
The table below details each contraception related attendance.²³

Table 3. Number²⁴ of contraceptive related attendances at SRH Services by type of method and age group (years), among residents of St. Helens: 2016

Choice	Method	<16	16-17	18-19	20-24	25-34	35-44	45+	Total ²⁵
Long acting reversible contraception (excluding injections)	Intrauterine Device	0	10	10	85	180	100	30	415
	Intrauterine System	0	5	15	50	135	160	95	460
	Implant	50	145	195	380	485	190	65	1,520
	TOTAL LARC (excluding injections)	50	160	220	520	800	450	195	2,395
Injectable	Injectable Contraceptive	20	100	180	540	615	290	30	1,780
User dependent methods (UDM)	Oral Contraceptive ²⁶	320	910	1,020	2,050	1,915	740	295	7,255
	Male Condom	445	990	840	1,180	1,170	395	175	5,190
	Female Condom	0	0	0	5	0	0	0	5
	Contraceptive Patch	5	10	25	55	35	5	0	135
	Natural Family Planning	0	0	0	0	5	0	0	5
	TOTAL UDM²⁷	765	1,915	1,885	3,295	3,130	1,140	470	12,600

Source: SRHAD. Data from Sexual and Reproductive Health Services.

Figure 49. Chosen main method of contraception, St.Helens residents 2016



²³ Injectable contraception is excluded from the LARC category due to reliance on users' compliance to turn up promptly for subsequent dose every 12 weeks. In addition, emergency contraception is excluded from the LARC and user dependent methods (UDM) totals.

²⁴ Please note, to prevent deductive disclosure the underlying number of contraceptive methods prescribed has been rounded to the nearest 5. Therefore the totals may not equal the sum of their parts.

²⁵ The totals include those with unknown age.

²⁶ Includes combined pill and progesterone only pill.

²⁷ Includes vaginal ring, cap/diaphragm and spermicides.

Figure 50. Chosen main contraception by Age Group, St.Helens residents 2016

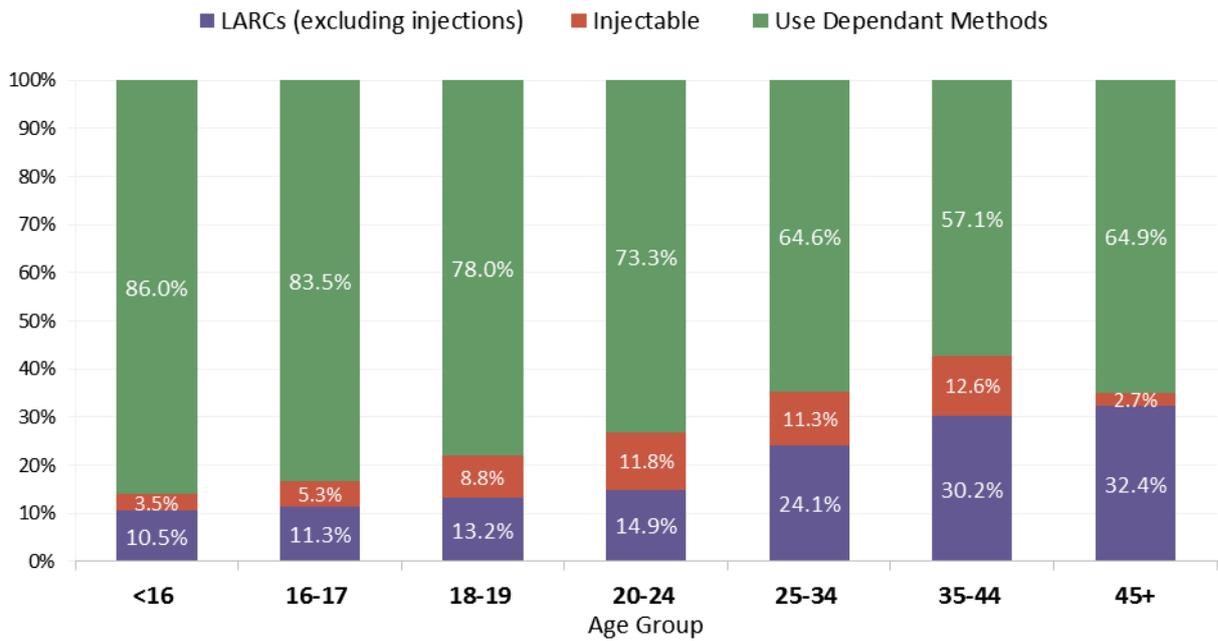
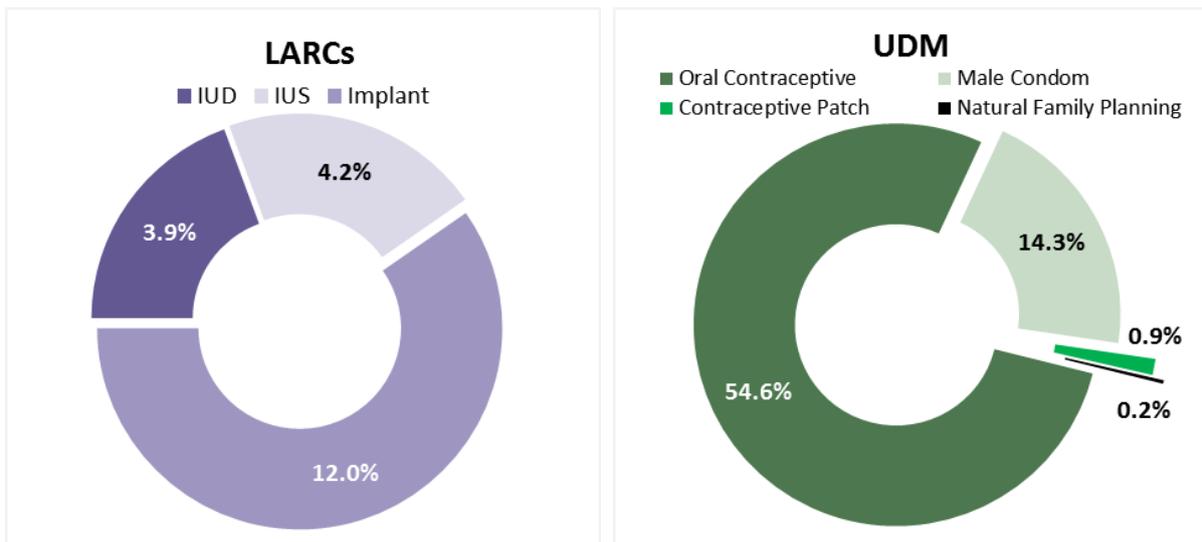
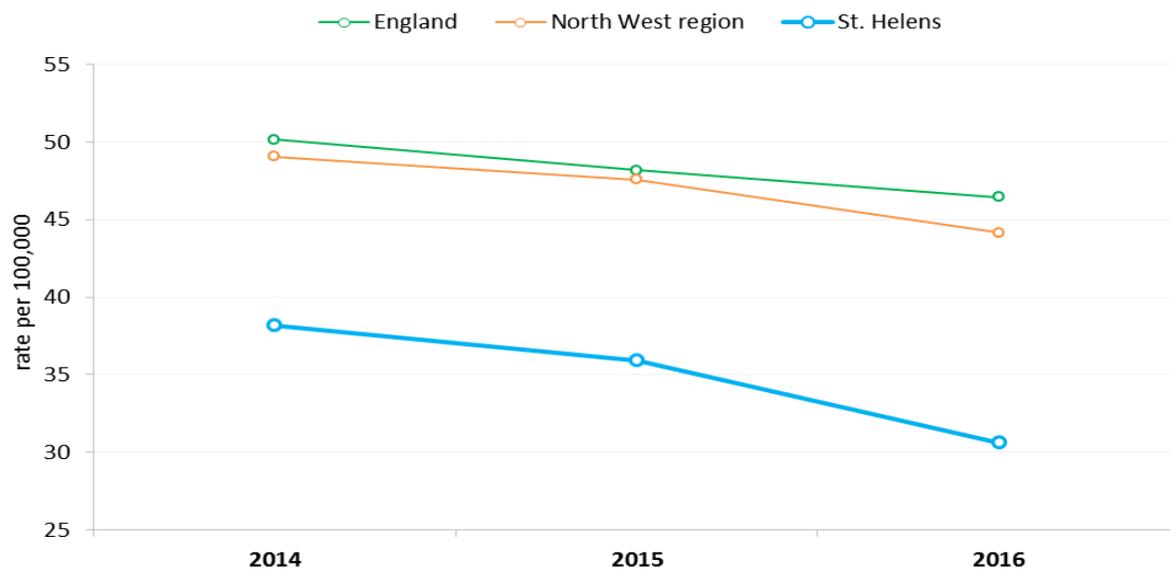


Figure 51. Breakdown of long acting reversible contraception (LARCs) and user dependent methods of contraception (UDM). St.Helens 2016



The charts below illustrate the rate of long acting reversible contraception prescribed in a primary care setting between 2011 and 2016.

Figure 52. Rate of GP and SRHS prescribed LARC (excluding injections) per 1,000



In 2016, St.Helens was ranked among the lowest local authorities in England for the rate of GP prescribed LARCs, with a rate of 3.9 per 1,000 women aged 15 to 44 years, compared to 20.7 for the North West and 28.8 in England.

St.Helens People's Board

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St Helens
Clinical Commissioning Group


Halton & St Helens
Voluntary and Community Action



Bridgewater Community Healthcare 
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