Women's Health Profile for Wirral

Wirral Intelligence Service

November - 2022

Key findings

- While women in the UK on average live longer than men, women spend a significantly greater proportion of their lives in ill health and disability when compared with men
- Delayed diagnosis is a significant issue for the estimated 1 in 10 women with endometriosis, who often delay seeking help due to the perception that pelvic pain is 'normal'; delayed diagnosis then leads to increased pain and suffering, prolonged ill health and a condition that becomes more difficult to treat
- Around 1 in 10 women are estimated to have the hormonal disorder PCOS (Polycystic Ovary Syndrome), symptoms of which are include excess hair (hirsutism), weight gain, acne and infertility and may also result in a woman suffering from depression, anxiety and other mental health issues such as low self-confidence or poor body image
- Although Wirral had a higher chlamydia detection rate than England in 2021; rates were still below target; this is of concern as untreated chlamydia causes avoidable sexual and reproductive ill-health, including symptomatic acute infections and complications such as Pelvic Inflammatory Disease (PID), ectopic pregnancy and infertility
- Hospital admissions for PID were 82% higher in Wirral than in England overall in 2020/21
- Wirral performs poorly on several important risk factors for pregnancy loss and stillbirth (e.g. deprivation levels, maternal obesity and maternal smoking; while performing better than comparators on others (and access to early maternity care, multiple births, low birth weight)
- The proportion of new birth visits which were conducted within 14 days in Wirral in 2020/21 was 91.8%, which was significantly better than both the North-West and England overall
- On both breastfeeding indicators (initiation and at 6-8 weeks), Wirral performed significantly worse than England
- Evidence shows that unplanned pregnancies result in poorer outcomes for women and their babies; choice and control over reproduction are important to ensure that as many pregnancies as possible are planned and wanted, health is optimised and women who do not wish to have children can effectively prevent pregnancy
- Childbirth presents an opportunity to do this at a time when women are attending a service staffed by healthcare providers with the skills to offer a full range of methods and when women may be motivated to start using an effective method
- Menopausal women are the fastest growing demographic in the workforce and almost eight out of 10 of menopausal women are in work
- Since 2018/19, there has been 54% increase in HRT (hormone replacement therapy) prescriptions dispensed in Wirral, compared to a 57% increase in England overall
- Half of mental health conditions start before the age of 14 and 75% before the age of 24
- The prevalence of all mental health disorders among children aged 5-15 has risen in the previous 20 years; the sharpest rise has been in emotional disorders (for example: anxiety, depression, OCD, phobias), which are more common among girls
- Wirral is an outlier (significantly worse than England) for all CHiMAT (Child & Maternal Health) indicators relating to mental health, self-harm, alcohol and substance misuse
- Local analysis showed that young females had higher rates of A&E attendances and hospital admissions than males for reasons that are often related to mental health (eating disorders, alcohol, substance misuse and self-harm); although females appeared to have higher need (evidenced by A&E attendances and hospital admissions), referrals and contacts with CAMHS (Child & Adolescent Mental Health Service), were roughly equal between the sexes, suggesting potential unmet need in females
- Certain risk factors are more likely to impact a women's mental health such as experiencing

sexual violence, abuse (mental, physical and sexual), caring responsibilities and socio-economic status; there are also female specific issues which affect mental health such as peri/post-natal depression and menopause
- Coverage dropped in all 3 the cancer screening programmes (cervical, breast and bowel) due to the pandemic, with breast screening rates particularly sharply affected
- HPV vaccination plummeted in Wirral from 90.5% to 53.9% in 2019/20 (due to COVID-19); rates have now recovered and were 89.0% in 2020/21 (higher than England)
- In Merseyside, 6% of domestic abuse cases discussed at MARACs (Multi-Agency Risk Assessment Conferences) in 2020/21 involved a male victim; 94% involved a female victim
- Merseyside Police had one of the highest rates of domestic abuse related crime in England & Wales in 2020/21; 19% of all domestic abuse related crimes resulted in an arrest in Merseyside in 2020/21, compared to 32% in England and Wales overall
- The Crime Survey for England and Wales (CSEW) found that women were around three times as likely as men to have experienced sexual abuse before the age of 16 years; females account for the majority of victims of sexual offences against children (80% female, 20% male)
- Of the total of 2,725 total 'honour based' abuse offences recorded in England & Wales in 2020/21, 29 were recorded by Merseyside Police
- Older women were more likely to be living alone compared to men in Wirral in 2020; at age 75+, an estimated 29% of men lived alone compared to 50% of women
- Women are more vulnerable to the impacts of alcohol at lower levels of consumption for various physiological reasons; women who drink excessively also tend to develop addiction and other medical issues more quickly than men; evidence also suggests that women are less likely, over the lifetime, to enter substance misuse treatment compared to males
- On the majority of alcohol indicator outcomes recorded by OHID, women in Wirral perform significantly worse than their counterparts in England
- Coronary Heart Disease (CHD) kills twice as many women as breast cancer in the UK
- Those who receive an incorrect initial diagnosis for heart attack have a 70% higher risk of death after 30 days (vs. someone who receives the correct diagnosis straightaway); women are 50% more likely than men to receive the wrong initial diagnosis for a heart attack
- Women with pregnancy complications are at higher risk of developing heart and circulatory diseases later in life
- Women who have similar risk factors to men have a greater chance of developing CHD; a lack of awareness of this 'excess risk', means that women often dramatically underestimate their risk of CHD; also, women who have established CHD are less likely than men to reduce the chances of a further heart attack by managing their risk factors
- Prevalence estimates for osteoporosis produced by NICE applied to the Wirral population of women aged 80+ in 2021 (Mid Year Population Estimates) equate to around 5,900 women with osteoporosis (with a consequent susceptibility to fracture), most of whom will be undiagnosed and unaware that they have the condition
- In Wirral in 2020/21, 71% of those who were admitted to hospital with hip fracture were women
- Incontinence has been named by older people as second only to dementia as their top fear related to ageing and is associated with social isolation and; a higher proportion (and number) of women are likely to be experiencing continence issues compared to men
- Admissions to hospital for UTIs (urinary tract infections) were higher in women in Wirral (long term trend); UTIs often result in delirium in older people, which has consequences for independence and admissions to a care home

Wirral JSNA: - Women's Health Profile

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What do we know?

Why is this important?

The Women's Health Strategy 2022 states that while women in the UK on average live longer than men, women spend a significantly greater proportion of their lives in ill health and disability when compared with men and notes that historically, the health and care system has been designed by men for men [1]. This 'male as default' approach has been seen in research and clinical trials, education and training for healthcare professionals and the design of healthcare policies and services [1].

The strategy points out that this has led to gaps in the data and evidence base that mean not enough is known about conditions that only affect women (e.g. menopause or endometriosis), or conditions that affect both men and women but impact them in different ways (e.g. cardiovascular disease, dementia or mental health conditions). It has also resulted in inefficiencies in how services are delivered – for example, women must move from service to service to have their reproductive health needs met and often struggle to access basic services such as contraception.

The impact of failing to put women at the heart of health services has been clear to see through the number of recent high-profile independent reports and inquiries which have shown that it is often women whom the healthcare system fails to keep safe or listen to.

The LGA have highlighted that women make up almost 70% of the local government workforce and almost three quarters of that workforce are 40-64 years old [10]. The proportion of the NHS's 1.3 million staff who are female is even higher, at 77% [13] and among the adult social care workforce it is higher again, at 82% [14]. For comparison, among the working age population in England overall, women comprise 47% of the workforce (men comprise 53%) [13].

National and local policy context

National policy context

The priority areas identified in the Women's Health Strategy 2022 mentioned above are:

- Menstrual health and gynaecological conditions
- Fertility, pregnancy loss and post-partum support
- Menopause
- Mental health & wellbeing
- Cancers
- Health impacts of violence against women and girls
- Healthy ageing and long-term conditions

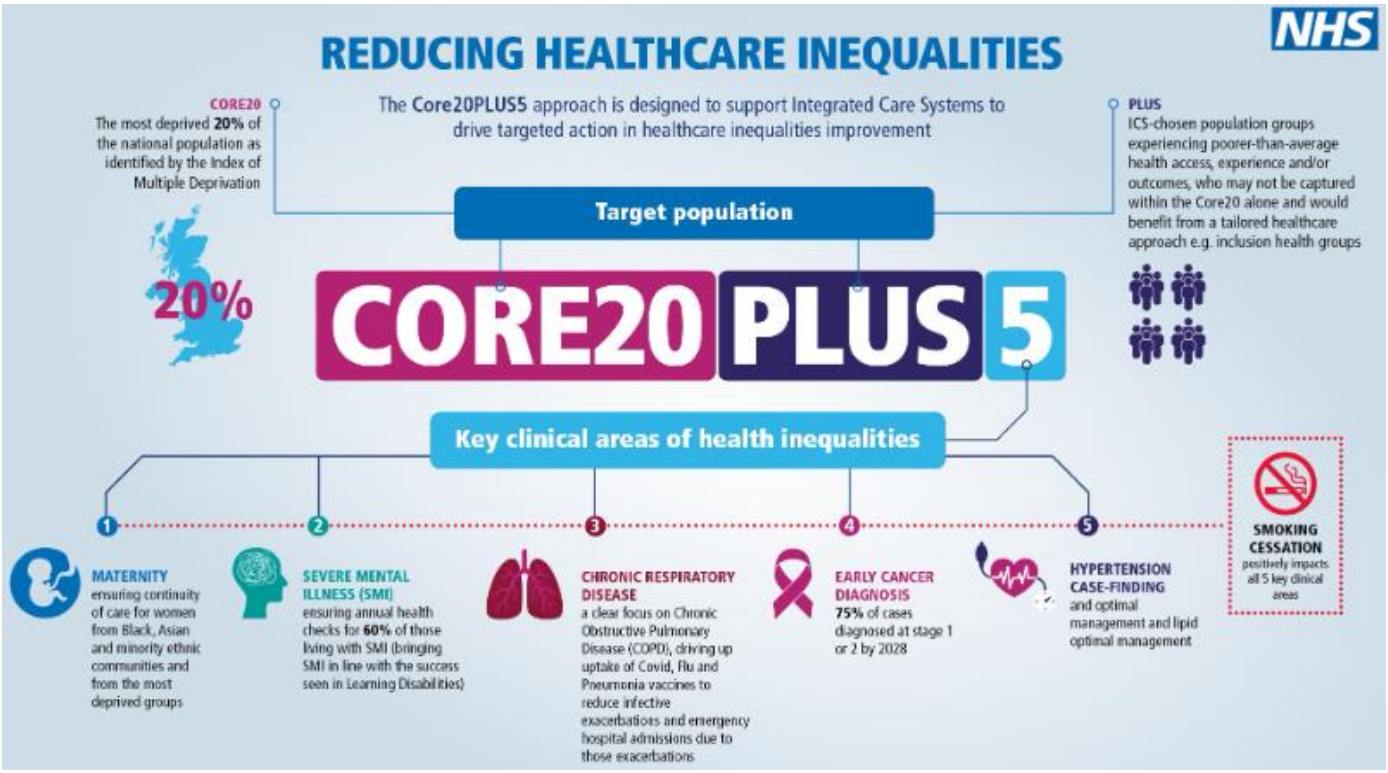
These areas have been used as the framework for this profile on Womens health in Wirral. Core20PLUS5 is a national NHS England and NHS Improvement approach to support the reduction of health inequalities at both national and system level. The approach defines a target population cohort – the 'Core20PLUS' – and identifies '5' focus clinical areas requiring accelerated improvement.

Core20 refers to the most deprived 20% of the national population as identified by the national Index of Multiple Deprivation (IMD). The IMD has seven domains with indicators accounting for a wide range of social determinants of health.

PLUS refers to population groups we would expect to see identified are ethnic minority communities; inclusion health groups; people with a learning disability and autistic people; coastal communities with pockets of deprivation hidden amongst relative affluence; people with multi-morbidities; and protected characteristic groups; amongst others. Inclusion health groups include: people experiencing homelessness, drug and alcohol dependence, vulnerable migrants, Gypsy, Roma and Traveller communities, sex workers, people in contact with the justice system, victims of modern slavery and other socially excluded groups.

The **5** refers to the key clinical areas of health inequalities, of which one (maternity), is specific to women. The Maternity priority in the CORE20PLUS5 strategy is to ensure continuity of care for 75% of women from BAME communities and from the most deprived groups. See **Box 1**.

Box 1: CORE20+5 overview



Source: NHS England, 2022

Local policy context

The Wirral Domestic Abuse Alliance and the Wirral Safeguarding Children Partnership launched the Wirral Tackling Violence Against Women and Girls Strategy in December 2022. The strategy was developed to help professionals identify, prevent and respond to all gender based violence.

The strategy, and its four key priority areas of prevention and education; support for victims; reducing harm; and building safer communities, all aim to bring about a cultural shift leading to long-term change in attitudes, and to ensure that agencies and professionals are able to identify and respond to violence and abuse, whilst safeguarding and supporting victims. The strategy includes a comprehensive local delivery plan, and with its emphasis on prevention and education involves closer work with schools and colleges.

The Women's Health and Maternity Programme aim is to develop a safe, high quality, clinically and financially sustainable whole system model of care for women's and children's services across Cheshire and Merseyside. The programme brings together local organisations, colleagues, families and caregivers to engage in decision making about the services that are offered to meet the needs of women, their babies, and their families at the right time, in the right place by the right people.

The programme aims to enrich maternity teams through effective leadership, recruitment, retention, training and support for continuous development. Improving Me is a partnership of NHS organisations across Cheshire and Merseyside aiming to improve women's health and maternity experiences.

Insight

Menstrual health and gynaecological conditions

There are relatively few indicators in the PHOF (Public Health Outcomes Framework) relating to menstrual health and gynaecological conditions, and fewer still that show females separately (e.g. all STI data with the exception of chlamydia, shows males/females combined) and there are no indicators for example, that relate to menopause or menstrual conditions such as endometriosis.

Some exceptions are indicators such as those relating to LARC (Long Acting Reversible contraception – see Sexual & Reproductive Health JSNA for more information on this), TOP (Termination of pregnancy – again see Sexual & Reproductive Health JSNA for more information on this), HPV (Human Papillomavirus – although from 2019, this now includes males – see Cancer section), HIV testing and PID (Pelvic Inflammatory Disease).

The relevant indicators where data for females can be shown separately are provided below.

Endometriosis

Endometriosis is one of the most common gynaecological diseases needing treatment [16]. It is defined as the abnormal growth of endometrial-like tissue (the womb lining) *outside* of the uterus (womb) and is mainly a disease of the reproductive years. Endometriosis is typically associated with symptoms such as pelvic pain, painful periods, sub-fertility and a lower quality of life [16]. Women with endometriosis report pain, which can be frequent, chronic and/or severe, as well as tiredness, more sick days and significant physical, sexual, psychological and social impacts [16]. Endometriosis is an important cause of sub-fertility and this can also have a significant effect on quality of life [16]. Women may also have endometriosis without symptoms, so it is difficult to know how common the disease is in the population, but the Royal College of Obstetricians & Gynaecologists estimate that it affects around 1 in 10 women [15].

There are many ‘unknowns’ about endometriosis, e.g. it is unclear whether endometriosis is always progressive or can remain stable or improve with time [16]. Its exact causes are also unknown; what is known is that it is hormone mediated, is associated with menstruation [16] and women are more likely to develop endometriosis if a close relative has it [15].

Delayed diagnosis is a significant problem and women often delay seeking help because of a perception that pelvic pain is ‘normal’ [16]. Delays of 4 to 10 years can occur between first reporting symptoms and confirming a diagnosis [16]. Many women report that the delay in diagnosis leads to increased personal suffering, prolonged ill health and a disease state that is then more difficult to treat [16].

Diagnosis can only be made definitively by laparoscopic visualisation of the pelvis, but other, less invasive methods may be useful in assisting diagnosis, including ultrasound. Management options for endometriosis include pharmacological, non-pharmacological and surgical treatments. As endometriosis is an oestrogen-dependent condition, most drug treatments work by suppressing ovarian function and are contraceptive (meaning that women's priorities and

preferences for treatment may change over time and management strategies need to change to reflect this) [16]. Surgical treatment aims to remove or destroy endometriotic lesions. The choice of treatment depends on the woman's preferences and priorities in terms of pain management and/or fertility.

The NICE guideline makes recommendations for the diagnosis and management of endometriosis in community services, gynaecology services and specialist endometriosis services (endometriosis centres) [16].

PCOS (Polycystic Ovary Syndrome)

PCOS is a hormonal disorder that manifests during female puberty. It is estimated that around one in ten women suffer from the disorder and display a wide range of symptoms [43]. Symptoms for PCOS are varied and can include many clinical conditions, the most recognisable perhaps being hyperandrogenism (high levels of male hormones) and issues around menstruation/ ovulation [44]. Other symptoms related to PCOS include excess hair (hirsutism), weight gain, acne and infertility [45]. These symptoms may also result in a woman suffering from depression, anxiety and other mental health issues such as low self-confidence or poor body image. Diagnosis of PCOS usually involves meeting two of the following three criterion:

1. Irregular menstrual pattern
2. Raised levels of male hormones (androgens)
3. Scans showing cysts on ovaries

Upon diagnosis of PCOS, a woman may be treated by her GP or a specialist in gynaecology or endocrinology, depending on the severity of symptoms. With no severe symptoms, such as menstrual or fertility issues, PCOS can be managed with lifestyle changes, such as maintaining a healthy weight through healthy diet and exercise. In cases where symptoms are more problematic, women with insulin resistance (also associated with PCOS), may be offered Metformin (a medication typically prescribed to patients with Type 2 Diabetes). In other circumstances, hormonal contraceptives, such as the pill may be recommended; this type of treatment can also help with other symptoms such as acne and hirsutism [45].

NICE recommendations for the treatment and management of PCOS also includes offering screening for impaired glucose tolerance, investigating any sleep problems and monitoring emotional wellbeing, as well as referring women to additional resources of information and support [44].

Fertility, pregnancy loss and post-partum support

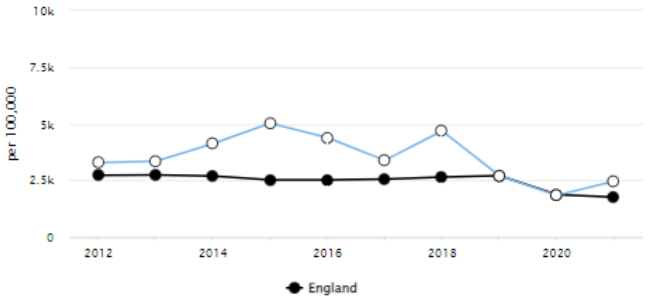
Chlamydia

Chlamydia is the most commonly diagnosed bacterial sexually transmitted infection in England, with rates substantially higher in young adults than any other age group [9]. It causes avoidable sexual and reproductive ill-health, including symptomatic acute infections and complications such as pelvic inflammatory disease (PID), ectopic pregnancy and tubal-factor infertility.

The National Chlamydia Screening Programme (NCSP) promotes opportunistic screening to sexually active young people aged under 25 years. In June 2021, changes to the programme were announced with a focus on reducing reproductive harm of untreated infection through opportunistic screening offered to young women aged under 25 years. This indicator relates to data until December 2021 when the NCSP offered screening to all young people under 25.

The chlamydia detection rate indicator is a measure of chlamydia control activity, an increased detection rate is indicative of increased control activity; the detection rate is not a measure of morbidity.

Figure 1: Chlamydia detection rate per 100,000 aged 15-24 (female)



Recent trend: ⬇ Decreasing

Period		Wirral Count	Wirral Value	Wirral 95% Lower CI	Wirral 95% Upper CI	North West	England
2012	○	601	3,282	3,025	3,555	3,091	2,723
2013	○	603	3,342	3,081	3,620	2,967	2,737
2014	○	723	4,122	3,827	4,433	3,179	2,701
2015	○	863	5,028	4,698	5,375	3,228	2,529
2016	○	727	4,392	4,079	4,723	3,075	2,529
2017	○	546	3,389	3,111	3,686	2,968	2,563
2018	○	748	4,683	4,354	5,032	2,951	2,651
2019	○	431	2,711	2,461	2,979	2,727	2,717
2020	○	296	1,850	1,645	2,073	1,717	1,882
2021	○	395	2,469	2,231	2,725	1,809	1,762

Source: PHOF, OHID, 2022

The UK Health Security Agency (UKHSA) recommends that local authorities should be working towards the revised female-only PHOF benchmark detection rate indicator (DRI) of 3,250 per 100,000 aged 15 to 24 (Female) [9]. As **Figure 1** shows, the Wirral rate in 2021 was 2,469 per 100,000; which although higher than the England detection rate (of 1,762 per 100,000 (was still considerably short of the target. Liverpool had the highest detection rate in the North-West region (3,170 per 100,000) and still did not achieve the target, followed by Wigan. Wirral had the 3rd highest rate in the North-West region on this measure [9]. Only 4 areas in England were achieving the target in 2021 (3 of which were in London).

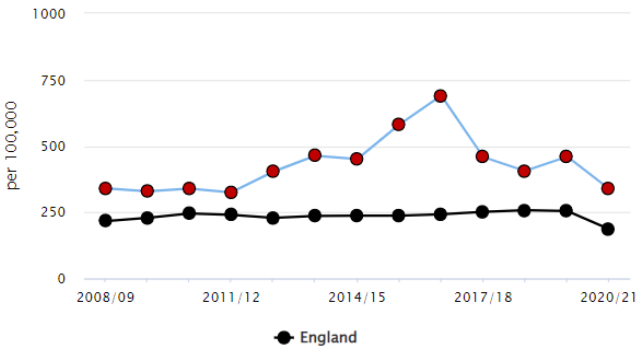
It should be noted that the detection rate among males was less than half that of females in Wirral in 2021 (1,041 per 100,000); this was a trend apparent both regionally and nationally (for males in this age group to have much lower chlamydia detection rates than females).

Please see the upcoming Sexual & Reproductive Health JSNA (which will be published here in January 2023 for more information).

Pelvic Inflammatory Disease (PID)

PID is the infection and inflammation of the female upper genital tract which can lead to serious complications such as ectopic pregnancy, tubal factor infertility and chronic pelvic pain. Although PID (and ectopic pregnancy) have multi-factorial causes, chlamydial infection and other sexually transmitted infections are major causes of both conditions. PID can be treated in both primary care and outpatient settings but may lead to the need for hospital admission. Ectopic pregnancy almost always results in hospital admission. OHID state that high chlamydia screening coverage *should* lead to increased chlamydia diagnoses which, assuming it is then successfully treated, should lead to a decrease in PID [9].

Figure 2: Trend in rate of hospital admissions for pelvic inflammatory disease (PID), Wirral and England, 2008/09 to 2020/21



Recent trend: ⬇ Decreasing & getting better

Period		Wirral Count	Value	95% Lower CI	95% Upper CI	North West	England
2008/09	●	204	340.1	295.0	390.1	250.9	216.4
2009/10	●	196	329.0	284.6	378.4	263.8	228.8
2010/11	●	200	339.0	293.7	389.4	267.0	245.5
2011/12	●	190	324.8	280.2	374.4	262.8	239.7
2012/13	●	233	403.1	353.0	458.3	257.1	228.4
2013/14	●	265	463.2	405.8	518.8	275.0	235.7
2014/15	●	255	450.8	398.8	511.5	307.8	236.4
2015/16	●	325	580.6	522.6	651.1	308.0	237.0
2016/17	●	380	689.7	622.1	762.7	317.0	242.4
2017/18	●	250	458.4	403.3	518.9	321.6	250.9
2018/19	●	220	405.4	355.3	464.6	342.7	257.6*
2019/20	●	250	459.5	402.6	518.2	327.1	254.7
2020/21	●	185	338.3	293.0	392.7	228.3	186.2

Source: PHOF, OHID, 2022

Wirral's admission rate for PID has remained significantly above that of England for the whole of the time period shown and the gap between England and Wirral's rates has increased (Wirral's rate was 57% higher than England in 2008/09; this had widened to 82% higher in 2020/21). This is because although over the time period shown, both Wirral and England have decreased, Wirral has not decreased as fast as England. In Wirral, the rate decreased by just 0.5% between 2008/09 and 2020/21; England's rate decreased by 14% over the same period [9]. There was a large peak in admissions in Wirral in 2016/17 which was not matched by a corresponding peak in either England or the North-West overall. Reasons for this are unclear.

Pregnancy loss and stillbirth overview

Table 1 below shows a summary of how Wirral, the North-West, England and Sefton (a near statistical neighbour) perform on several important risk factors for pregnancy loss and stillbirth. Trend data (where available) for each indicator will also be presented separately below the table for both historical context and to show direction of travel (for Wirral and England).

Table 1: Comparison of risk factors for pregnancy loss and stillbirth in Wirral and comparators

Risk factor	Period	Wirral	England	North West	Sefton
Deprivation score (IMD 2019)	2019	**29.6**	**21.7**	**28.1**	**27.0**
% Teenage mothers (aged <18 years)	2020/21	**0.6%**	**0.6%**	**0.7%**	**0.7%**
Obesity in early pregnancy	2018/19	**26.4%**	**22.1%**	**23.6%**	**21.8%**
Early access to maternity care	2018/19	**61.4%**	**57.8%**	**56.8%**	**68.8%**
% Deliveries to women aged 35+	2020/21	**20.9%**	**23.4%**	**20.3%**	**22.9%**
% Deliveries to BAME mothers	2020/21	**4.7%**	**21.6%**	**18.5%**	**4.2%**
Premature births (<37 weeks gestation)	2018-20	**74.4**	**79.1**	**83.5**	**80.0**
% Smoking at time of delivery	2021/22	**11.4%**	**9.0%**	**10.6%**	**9.0%**
% Low birthweight of *all* babies (<2,500g)	2020	**6.6%**	**6.9%**	**6.9%**	**6.7%**
% Low birthweight of *term* babies (<2,500g)	2020	**2.4%**	**2.9%**	**2.7%**	**2.4%**
Multiple births (rate per 1,000)[2]	2020	**11.6**	**14.4**	**13.5**	**16.4**

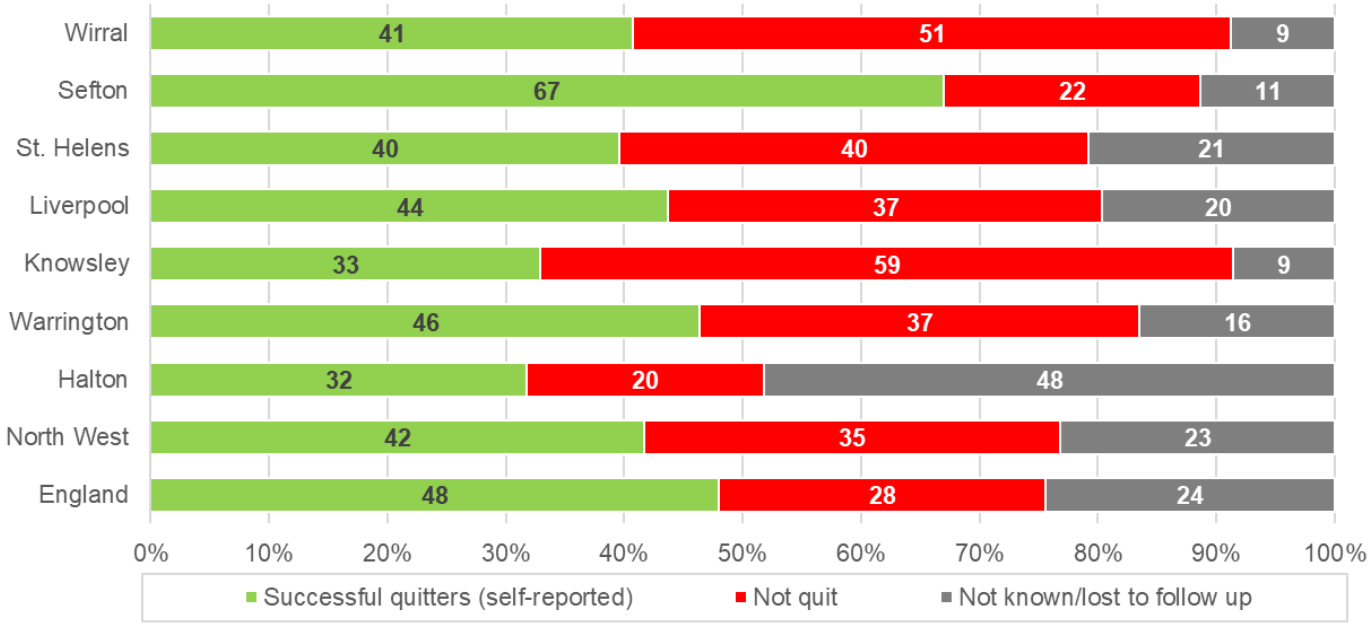
Sources: Office for Health Improvement & Disparities (formerly Public Health England) https://fingertips.phe.org.uk/profile-group/child-health/profile/child-health-overview

Note: Colour coding using RAG ratings (Red = significantly worse than England; Amber = not significantly different to England; Green = significantly better than England). Where there is no RAG rating, this is because these indicators are not suitable for classification into 'better' or 'worse'.

Smoking in pregnancy

In 2019/20, Wirral had the lowest proportion of women who successfully quit smoking in pregnancy of all the Cheshire & Merseyside (C&M) authorities (and also the lowest rate of quits confirmed by CO validation), with fewer than 1 in 3 pregnant women quitting [8]. **Figure 3** below shows updated information for 2020/21 and demonstrates that this is no longer the case, with 41% of pregnant women in Wirral successfully quitting during pregnancy. Despite this improvement, this rate is still however, a lower quit rate than both England (48%) and the North-West overall (42%).

Figure 3: Proportion of pregnant women successfully quitting smoking during pregnancy, England, North-West and Cheshire & Merseyside Local Authorities, 2020/21



Source: NHS Digital, Statistics on Stop Smoking Services, 2022
Note 1: CO Validation data negligible for 2020/21. Of the 8,678 reported successful quits in England, only 385 were CO validated. In the 9 C&M Authorities, the total number of CO validated quits was 14 (in Wirral, the figure was 1)
Note 2: No data submitted for Cheshire East and Cheshire West & Chester

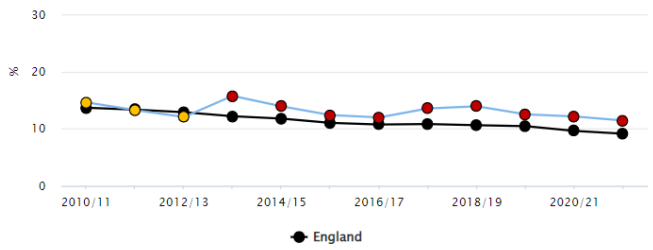
Prior to 2020/21, the number and proportion of successful quits which were CO validated was monitored by providers and shared by NHS Digital. However, since the COVID-19 pandemic, there has been a reduction in CO monitoring and an increased preference for telephone support from the Stop Smoking service provider in Wirral (A Better Life or ABL). This has meant the number of successful quits validated by CO monitoring is currently very small. There is however, work underway as part of the NHS Long Term Plan, Treating Tobacco Dependence programme. which should increase in CO monitoring again.

Smoking at the time of delivery

Smoking in pregnancy has well evidenced to negatively affect the growth and development of the baby and health of the mother. On average, smokers have more complications during pregnancy and labour, including bleeding during pregnancy, placental abruption, premature rupture of membranes, an increased risk of miscarriage, premature birth, stillbirth, low birth-weight and sudden unexpected death in infancy [9]. Encouraging pregnant women to stop smoking during pregnancy may also help them stop smoking permanently and thus provide health benefits for the mother and reduce exposure to secondhand smoke among infants [9].

The Tobacco Control Plan contained a national ambition to reduce the rate of smoking throughout pregnancy to 6% or less by the end of 2022, which will not be met in England overall, where the rate in 2021/22 was 9.1% of women still smoking at the time of delivery. There are many areas of England where the target will be met; almost all are in the South-East. For example, the 8 Local Authorities with the lowest rates of smoking at the time of delivery in England were all in London boroughs and all had rates of 3.1 to 3.2% in 2021/22.

Figure 4: Trend in proportion of pregnant women smoking at the time of delivery in Wirral and England, 2010/11 to 2011/12



Period		Wirral Count	Value	95% Lower CI	95% Upper CI	North West	England
2010/11		523	14.6%	13.5%	15.8%	17.8%	13.6%
2011/12		479	13.2%	12.2%	14.4%	17.1%	13.3%
2012/13		418	12.0%	11.0%	13.1%	16.5%	12.8%
2013/14		420	15.7%*	14.4%	17.1%	15.5%	12.2%
2014/15		364	13.9%*	12.6%	15.3%	14.8%	11.7%
2015/16		354	12.4%*	11.2%	13.6%	13.8%	11.0%
2016/17		348	12.0%*	10.8%	13.2%	13.4%	10.7%
2017/18		379	13.5%*	12.3%	14.9%	13.4%	10.8%
2018/19		422	13.9%	12.7%	15.2%	12.7%*	10.6%
2019/20		372	12.5%	11.3%	13.7%	12.2%*	10.4%
2020/21		339	12.1%	11.0%	13.4%	11.0%	9.6%
2021/22		330	11.4%	10.3%	12.6%	10.6%	9.1%

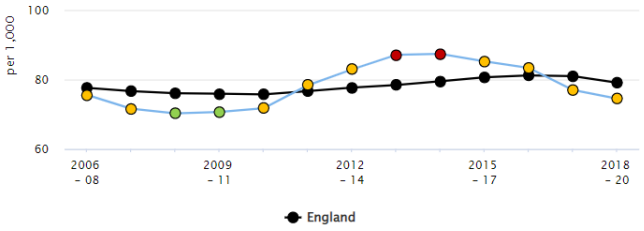
Source: PHOF, OHID, 2022

Over the decade shown in **Figure 4** above, smoking at the time of delivery has reduced in Wirral from 14.6% to 11.4%; this is a slightly more modest reduction (of 22%) compared to the reduction in England (33%) and the North-West (40%) over the same period.

Prematurity

Globally, premature birth (less than 37 weeks gestation) is the leading cause of deaths in children aged 5 and under [9]. It is well evidenced that smoking during pregnancy and exposure to second hand smoke can lead to premature birth (among many other adverse health effects including labour complications, low birth-weight and increased risk of miscarriage and stillbirth) [9].

Figure 5: Trend in rate of premature births (<37 weeks), Wirral and England, 2006-08 to 2018-20



Period		Wirral Count	Value	95% Lower CI	95% Upper CI	North West	England
2006 - 08		837	75.6	70.5	80.9	78.9	77.6
2007 - 09		798	71.6	66.7	76.7	77.5	76.7
2008 - 10		788	70.2	65.4	75.3	76.7	76.0
2009 - 11		794	70.7	65.9	75.8	77.0	75.9
2010 - 12		818	71.7	66.9	76.8	77.9	75.7
2011 - 13		875	78.4	73.2	83.7	79.6	76.7
2012 - 14		903	82.9	77.6	88.5	81.4	77.6
2013 - 15		932	87.1	81.6	92.9	82.7	78.4
2014 - 16		924	87.4	81.8	93.2	84.7	79.5
2015 - 17		886	85.2	79.7	91.1	86.0	80.6
2016 - 18		840	83.3	77.8	89.2	86.3	81.2
2017 - 19		754	77.0	71.6	82.7	85.3	81.0
2018 - 20		699	74.5	69.1	80.2	83.5	79.1

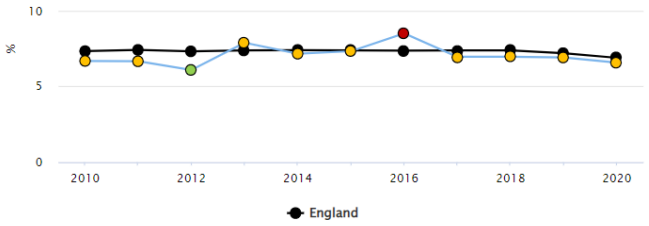
Source: PHOF, OHID, 2022

As **Figure 5** shows, premature births have shown a considerable improvement in Wirral since 2014-16 (when the rate was 87.4 per 1,000 births and significantly worse than England), and 2018-20 when it had reduced to 74.4 per 1,000 births (and was not significantly different to England). In numbers, this is a reduction from 924 premature births in 2014-16, to 699 in 2018-20 (24% reduction). Wirral had the second lowest rate of prematurity in the North-West in 2018-20.

Low birthweight

Low birthweight is a major factor in infant mortality and has serious consequences for health in later life [9]. There are wide inequalities in low birthweight and these inequalities are likely to affect future childhood and adult health inequalities [9].

Figure 6: Trend in proportion *all* babies who are low birthweight (<2,500g)



		Wirral					
Period		Count	Value	95% Lower CI	95% Upper CI	North West	England
2010		253	6.7%	5.9%	7.5%	7.2%	7.3%
2011		254	6.6%	5.9%	7.5%	7.4%	7.4%
2012		233	6.1%	5.4%	6.9%	7.2%	7.3%
2013		281	7.9%	7.0%	8.8%	7.3%	7.4%
2014		254	7.2%	6.3%	8.0%	7.4%	7.4%
2015		261	7.3%	6.5%	8.2%	7.5%	7.4%
2016		293	8.5%	7.6%	9.5%	7.5%	7.3%
2017		234	6.9%	6.1%	7.8%	7.6%	7.4%
2018		226	6.9%	6.1%	7.9%	7.6%	7.4%
2019		218	6.9%	6.1%	7.8%	7.3%	7.2%
2020		194	6.6%	5.7%	7.5%	6.9%	6.9%

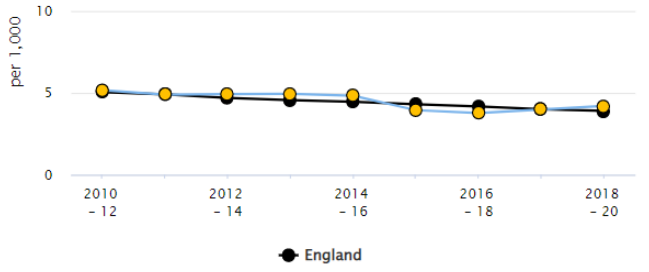
Source: PHOF, OHID, 2022

Over the decade shown in **Figure 6** above, the proportion of all babies who were classified as low birthweight (<2,500g), has reduced in Wirral was 6.6% in 2020 - which is a lower proportion than both England (6.9%) and the North-West (also 6.9%).

Stillbirth

Stillbirth rates in the United Kingdom have shown a gradual decline over the last 20 years, but the rate remains one of the highest in high income countries [9]. Risk factors associated with stillbirth include maternal obesity, ethnicity, smoking, pre-existing diabetes, history of mental health problems, antepartum haemorrhage and foetal growth restriction (birth weight below the 10th customised weight percentile). In 2015, the government announced an ambition to halve the rate of stillbirths by 2030 [9]. Since that announcement in 2015/16, the stillbirth rate in England has decreased by 9% while in Wirral it has increased by 7% (comparing rates in 2015-17 to 2018-20). **Figure 7** below shows the trend in the rate of stillbirths in Wirral and England, between 2010-12 and 2018-20.

Figure 7: Trend in the rate (per 1,000) of stillbirths in Wirral and England, 2010-12 and 2018-20.



		Wirral					
Period		Count	Value	95% Lower CI	95% Upper CI	North West	England
2010 - 12		59	5.2	3.9	6.6	5.3	5.0
2011 - 13		55	4.9	3.7	6.4	5.2	4.9
2012 - 14		54	4.9	3.7	6.4	5.0	4.7
2013 - 15		53	4.9	3.7	6.5	4.8	4.6
2014 - 16		51	4.8	3.6	6.3	4.5	4.5
2015 - 17		41	3.9	2.8	5.3	4.4	4.3
2016 - 18		38	3.8	2.7	5.2	4.2	4.2
2017 - 19		39	4.0	2.8	5.4	4.1	4.0
2018 - 20		39	4.2	3.0	5.7	4.1	3.9

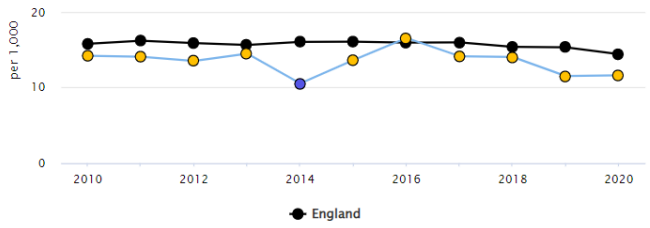
Source: PHOF, OHID, 2022

As **Figure 7** shows, the rate of stillbirths in Wirral has increased for the previous 2 time periods, compared to a steady but gradual decline in England overall. Since 2010-12, there has been a 19% decrease in stillbirths in Wirral, compared to a 22% decrease in England (despite increases in the 2 time most recent time periods).

Multiple births

Compared with singleton births, babies from multiple births have much higher rates of stillbirth, neonatal mortality, infant mortality, preterm birth, low birth weight, congenital anomalies and subsequent developmental problems [9]. All of these have consequences for families and for society [9]. Rates of multiple birth are influenced by differences in the proportions of older women giving birth, the extent of use of ovarian stimulation and assisted conception, as well as other factors [9].

Figure 8: Trend in the rate (per 1,000) of multiple births in Wirral and England, 2010-2020



	Wirral						
Period		Count	Value	95% Lower CI	95% Upper CI	North West	England
2010		53	14.2	10.6	18.5	14.4	15.7
2011		53	14.1	10.5	18.4	15.2	16.2
2012		51	13.5	10.0	17.7	14.3	15.9
2013		51	14.5	10.8	19.0	14.2	15.6
2014		37	10.5	7.4	14.5	14.2	16.0
2015		48	13.6	10.0	18.0	14.5	16.0
2016		56	16.5	12.5	21.4	14.4	15.9
2017		47	14.1	10.9	18.5	14.0	15.9
2018		45	14.0	10.2	18.8	14.0	15.4
2019		36	11.5	8.1	15.9	13.9	15.3
2020		34	11.6	8.0	16.2	13.5	14.4

Source: PHOF, OHID, 2022

Post-partum support

Some indicators which may give an indication of post-partum support (although in the case of breastfeeding, while support may be very important, there is evidence that most women have decided on how they will feed their baby a long time before the baby is born) are shown in **Table 2** below.

Table 2: Indicators of post-partum support, Wirral and comparator areas

Indicator	Period	Wirral	England	North West	Sefton
% New birth visits conducted within 14 days	2020/21	**91.8%**	**88.0%**	**87.9%**	**92.6%**
% Breastfeeding initiation	2018/19	**58.7%**	**67.4%**	**62.4%**	**56.4%**
% Breastfeeding prevalence at 6-8 weeks after birth	2020/21	**31.9%**	**49.3%**	*	**36.5%**

Source: PHOF, OHID, 2022

Note: Data unavailable for North-West overall due to the large number of areas who did not meet data quality requirements. Breastfeeding initiation (or babies first feed breastmilk) not updated across England since 2018/19 for reasons which are unclear.

As **Table 2** shows, the proportion of new birth visits which were conducted within 14 days in Wirral in 2020/21 was 91.8%, which was significantly better than both the North-West and England overall. On both breastfeeding indicators, Wirral performed significantly worse than England (although the initiation indicator is now quite out of date, no more recent data is available and as mentioned above, these may only be loosely indicative of post-partum support). A number of local public health interventions are provided in Wirral to provide post-partum support, reduce the health inequalities and improve maternal and infant outcomes; they are summarised in **Table 3** below.

Table 3: Local interventions/projects/services working to improve maternal and infant outcomes

Name	Details of Intervention/project
Koala NW	Provides a range of services and support to children and their families in the critical 1,001 days, e.g. Ante-natal and Post-natal breastfeeding peer support, Parent and Infant Mental Health Service. Tailored to need using a responsive, user-led approach
Infant Feeding Team	Provides information, support and training to healthcare professionals to ensure a high standard of care for pregnant women and breastfeeding mothers and babies
0-19 Health & Wellbeing Service	Offers services starting in the Antenatal period including support from the Health Visiting and Family Nurse Partnership (FNP) team, regular health reviews and infant feeding support. Safe sleep guidance is shared with all families when visited for targeted antenatal and universal birth visits.
Parentcraft (Antenatal) sessions	Practical guidance and advice for the first few months of parenthood. Takes place in the community, often in local Children's Centres.
Early Childhood Services	Brings together a range of services for families and children from pre-birth to five. The services give families access to universal and targeted help at the earliest opportunity from accessing universal groups to targeted family support. They empower families to access community services.
ABL (A Better Life – Wirral's Stop Smoking Service)	Wirral's specialist treatment and behavioural support service for people who want to quit smoking (including those that wish to quit using an e-cigarette) has a specialist pregnancy adviser who provides a tailored support offer to pregnant smokers and their partners.

Source: Wirral Infant Mortality Report, 2018-20

Post-natal contraception

Recent years have seen calls for contraception to be delivered to women post-partum in maternity settings (FSRH; NICE). A report by the Royal College of Obstetricians and Gynaecologists (RCOG. Better for Women. Improving the health and wellbeing of girls and women. 2019) states that post-pregnancy contraception should be a key part of the maternity pathway, recommending that all midwives and allied professions be trained to provide this.

More than 3 in 4 women at any one time want to either prevent or achieve pregnancy; contraception and pre-conception care are therefore a day-to-day reality for the majority of women for most of their reproductive years [49]. Choice and control over reproduction is important to ensure that as many pregnancies as possible are planned and wanted, health is optimised both before a first pregnancy and in the inter-pregnancy period, and women who do not wish to have children can effectively prevent becoming pregnant. It is estimated that around 45% of pregnancies and one third of births in England are unplanned or associated with feelings of ambivalence [49].

There is clear evidence that unplanned pregnancies result in poorer outcomes for women and their babies due to late presentations for antenatal care and a wide range of obstetric complications during the pregnancy, delivery and postnatal period [49]. Mental health outcomes can also be impacted with increased incidence of antenatal and postnatal depression and higher rates of unplanned pregnancies are evidenced amongst key vulnerable or socially disadvantaged groups [49].

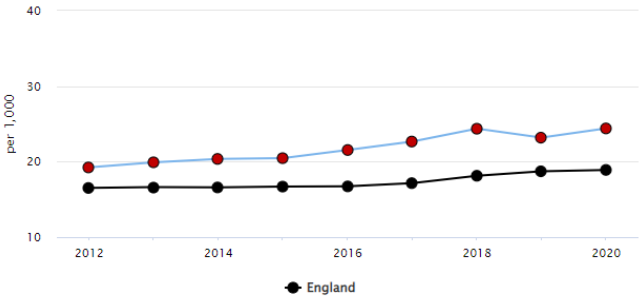
Childbirth presents an opportunity for providing contraception at a time when women are attending a service staffed by healthcare providers with the skills to offer a full range of methods and when women may be highly motivated to start using an effective method. This also provides a great opportunity to engage with the most vulnerable and marginalised women who are at increased risk of an unplanned pregnancy and poor outcomes [49].

In Wirral, postnatal contraception is not routinely prescribed within the maternity setting. The number of prescriptions for the progesterone only pill increased during 2020/21 in response to the pandemic (and as recommended by FSRH) but this has since declined. A small number of women have received a contraceptive injection or implant prior to discharge or an IUD/S (intrauterine device or intrauterine system) at Caesarean-section, but this tends to be very ad-hoc.

Abortion

Abortion rates can provide some indication of how readily people in an area can obtain good quality contraception and how effectively it is used. Wirral has a high abortion rate which is significantly higher than England and the North West (NW), see **Figure 9** below:

Figure 9: Wirral total abortion rate/ 1000 (2012-2020)



Recent trend: ➡ No significant change

Period		Wirral Count	Value	95% Lower CI	95% Upper CI	North West	England
2012	●	1,112	19.2	18.1	20.4	17.6	16.5
2013	●	1,139	19.9	18.8	21.1	17.6	16.6
2014	●	1,152	20.4	19.2	21.6	18.2	16.6
2015	●	1,145	20.5	19.3	21.7	18.5	16.7
2016	●	1,187	21.5	20.3	22.8	18.9	16.7
2017	●	1,236	22.7	21.4	24.0	19.5	17.2
2018	●	1,322	24.4	23.1	25.7	20.7	18.1
2019	●	1,261	23.2	21.9	24.5	21.3	18.7
2020	●	1,335	24.4	23.1	25.8	21.9	18.9

Source: Department of Health based on data from abortion clinics

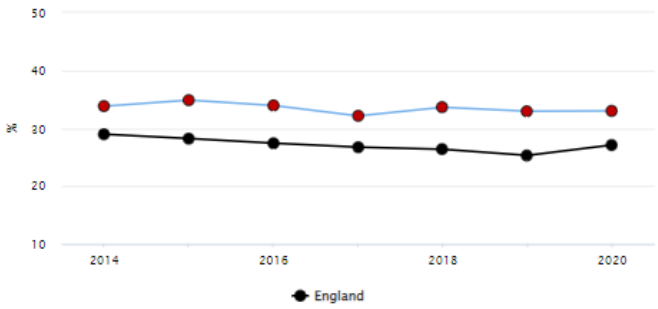
Source: PHOF, OHID, 2022

Repeat terminations are also a case for concern locally. Among women aged under 25 years that had an abortion in 2019, over a third (35.8%) had also had a previous abortion; this is significantly higher than the England and North West rate. When compared with statistical neighbours, Wirral performs poorly with the highest rate of repeat terminations.

Abortion in the under 25s following a birth

This indicator details the percentage of females (aged under 25 years) having an abortion, who had a previous birth in any year. The number of women in Wirral (aged under 25) having an abortion following a birth is high (one in three or 33% of Wirral women under 25 years presenting at a termination of pregnancy service have had a previous birth). The rate is significantly higher than the national average and is a clear indication of need to improve the post-partum contraception offer.

Figure 10: Wirral Under 25s abortion after a birth (%)



Recent trend: ➡ No significant change

Period		Wirral Count	Wirral Value	Wirral 95% Lower CI	Wirral 95% Upper CI	North West	England
2014		180	33.8%	29.9%	38.0%	32.2%	29.0%
2015		183	34.9%	30.9%	39.0%	31.7%	28.2%
2016		168	33.9%	29.9%	38.2%	30.6%	27.4%
2017		172	32.2%	28.3%	36.2%	30.2%	26.7%
2018		176	33.7%	29.7%	37.8%	29.5%	26.4%
2019		166	32.9%	29.0%	37.2%	27.6%	25.3%
2020		177	33.0%	29.2%	37.1%	30.1%	27.1%

Source: Department of Health

Source: PHOF, OHID, 2022

Menopause

Menopause is the biological stage in a woman's life that occurs when menstruation stops; it is usually defined as having occurred when a woman has not had a period for 12 consecutive months (for those reaching menopause naturally) [12]. The changes associated with menopause usually occur between the ages of 45 and 55, with symptoms lasting around 4 years [10].

A factsheet produced by the Local Government Association briefing on menopause states that menopausal women are the fastest growing demographic in the workforce and almost eight out of 10 of menopausal women are in work. This means that at any one time, a considerable proportion of the workforce may be experiencing symptoms of the menopause [10] (although it is important to note that not all women will experience negative and/or bothersome symptoms).

Symptoms range from cognitive, physical and psychological and it is important to note, that even women who do not experience obvious symptoms still undergo physiological changes that will have an impact on their health (e.g. increased risk of heart disease, CVD, poor bone density and osteoporosis) [12]. Some of the more commonly reported symptoms include [10]:

Box 2: Commonly reported symptoms of the menopause

- Hot flushes (sometimes followed by chills)
- Heart palpitations
- Fatigue
- Sleep disturbance
- Dry eye conditions
- Muscular aches
- Irritability, anxiety and/or mood disturbances
- Poor concentration, 'brain fog'
- The need for more toilet breaks
- Headaches
- Night sweats
- Skin irritation and itchiness

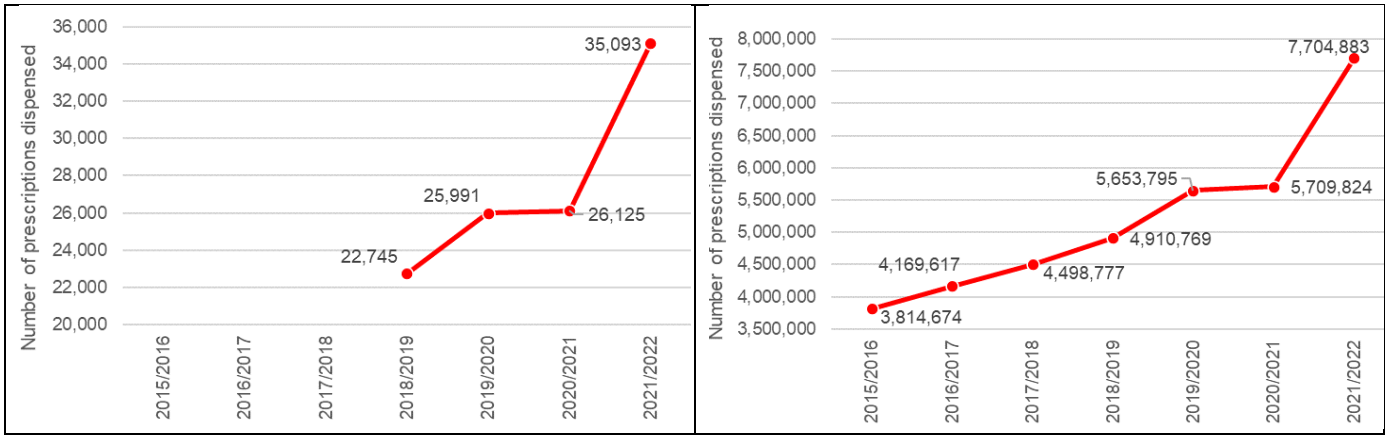
Source: Menopause factsheet, LGA [10]

NICE produced its first guidance on the menopause in 2015 (updated in 2019 and in the process of being updated again, since a review in September 2021). The guideline recommended women should be involved in discussions and make informed decisions about their care [12] and recommended that healthcare professionals should give information to menopausal women and their family members or carers, which should include:

- An explanation of the stages of menopause
- Common symptoms
- Lifestyle changes that can help their general health and wellbeing
- Benefits of and risks of the range of treatment for menopausal symptoms
- The long- term health implications of menopause

Advice and support available is variable, and use of hormone replacement therapy (HRT) – a treatment for common symptoms of menopause – varies with socioeconomic and cultural factors; around a million women in the UK use treatment for their menopausal symptoms [12]. The number of prescriptions for HRT almost halved after the publication of 2 large studies (the Women's Health Initiative in 2002 and the Million Women Study in 2003), but has in recent years, recovered. **Figures 11** and **12** below show the trend in the number of prescriptions of HRT dispensed in Wirral (**Figure 11**) and England (**Figure 12**) between 2015/16 and 2021/22.

Figures 11 and 12: Trend in number of HRT prescriptions in Wirral (left) and England (right), 2015/16 to 2021/22



Source: NHS Business Services Authority (NHSBSA), 2022
Note: Data for Wirral only available from 2018/19 onward. Charts show items dispensed, ***not*** persons. NHS dispensed prescriptions only, extend of private prescriptions is unknown

As **Figures 11** and **12** show, trends in Wirral and England is broadly similar; since 2018/19, there has been 54% increase in prescriptions dispensed in Wirral, compared to a 57% increase in England overall. Costs have doubled in England, from £36.5 million to £77.3 million a year [17].

The particularly steep increase in 2021/22 is thought to be due to a combination of a catch-up following difficulties in accessing health services during the pandemic and the response to campaigns – including notably, one led by the broadcaster Davina McCall – which have campaigned about the benefits of HRT and the cost of HRT prescriptions [17]. The government have announced that from April 2023, the cost of prescriptions for HRT products will be cut with the introduction of an annual prescription prepayment certificate. This will allow access to an annual supply of HRT therapies, for the cost of two prescription items at £18.70.
Other recent developments include the appointment of an 'HRT Tsar' to improve the supply of HRT products, pharmacists being given a temporary power to substitute some short-supply prescribed items to better meet demand and help ease current supply issues and the establishment of a new cross-government Menopause Taskforce [17]. The taskforce will consider the role education, training, workplace policies and peer groups can play in supporting women.

Mental health & wellbeing

According to the Royal College of Paediatrics and Child Health, half of mental health conditions in adults start before the age of 14 and 75% before the age of 24, while children and young people today are considered to have worse mental health outcomes compared to previous generations [18]. The college notes that although the prevalence of all mental health disorders among children aged 5-15 has risen in the previous 20 years, the sharpest prevalence rise has

been in emotional disorders (for example: anxiety, depression, OCD, phobias), which are more common among girls.

The prevalence of emotional disorders in children aged 5-15 were estimated to be 5.8% in 2017 (6.1% in girls compared to 5.6% among boys). This proportion increases with age, to 14.9% of young people aged 17-19, but again, was higher in young women, with 22.4% - so more than 1 in 4 of women in this age group were classed as having an emotional disorder [18].

Mental Health in Children & Young People

The Marmot Report [6] had as one of its five key objectives, 'Every child to have the best start in life', with the research underpinning this document showing that negative experiences early in life, particularly experiences of adversity, relate closely to many negative long-term outcomes including: poverty, unemployment, homelessness, unhealthy behaviours and poor mental and physical health [6].

Figure 12: Indicators relating to mental health, self-harm, alcohol and substance misuse in young people in Wirral

Indicator	Period	Wirral			Region	England		England
		Recent Trend	Count	Value	Value	Value	Worst	Range
Hospital admissions as a result of self-harm (10-24 years) (Persons, 10-24 yrs)	2020/21	↑	340	654.9	497.5	421.9	1,173.7	
Hospital admissions as a result of self-harm (Persons, 10-14 yrs)	2020/21	↑	80	408.3	336.1	213.0	640.3	
Hospital admissions as a result of self-harm (Persons, 15-19 yrs)	2020/21	→	155	898.9	726.0	652.6	1,596.1	
Hospital admissions as a result of self-harm (Persons, 20-24 yrs)	2020/21	→	105	658.0	435.3	401.8	1,661.6	
Admission episodes for alcohol-specific conditions - Under 18s (Male, <18 yrs)	2018/19 - 20/21	-	30	28.8	29.7	22.8	91.0	
Admission episodes for alcohol-specific conditions - Under 18s (Female, <18 yrs)	2018/19 - 20/21	-	55	55.9	51.0	36.1	111.3	
Admission episodes for alcohol-specific conditions - Under 18s (Persons, <18 yrs)	2018/19 - 20/21	-	85	42.0	40.1	29.3	83.8	
Emergency Hospital Admissions for Intentional Self-Harm (Persons, All ages)	2020/21	→	800	262.6	225.0	181.2	471.7	
Hospital admissions due to substance misuse (15-24 years) (Persons, 15-24 yrs)	2018/19 - 20/21	-	205	205.1	106.0	81.2	229.4	

As **Figure 13** shows, Wirral is an outlier (significantly worse than England) for all of the CHiMAT (Child & Maternal Health) indicators relating to mental health, self-harm, alcohol and substance Misuse. It is notable that these are predominantly long-standing trends and the only indicator on which Wirral is not significantly worse than England is for males aged <18.

Females aged <18 had a rate of 55.9 per 100,000; this was almost double the rate for males (55.9 per 100,000) and was also significantly higher than England (36.1 per 100,000).

A recent report produced for the Networked Data Lab (NDL) Project 2: Children & Young People's Mental Health in Liverpool and Wirral (2022) provided local insights on patterns of mental health service usage for children and young people living in both Liverpool and Wirral [5].

The Networked Data Lab (NDL) and University of Liverpool (UofL) worked with Wirral CCG following a report published by the Children's Commissioner which showed that rates of probable mental disorders in children had increased by 6% since 2018, to one in six (16%) by July 2020.

The impact of the pandemic and growing concern that child health, already at crisis point pre COVID-19, would suffer further as the country emerges from the pandemic

The proposed aims of the initial research were to investigate which population groups were at increased risk of negative mental health outcomes due to the COVID-19 crisis? What were the factors driving increased risk? How did they change over time and what was the associated change in demand for services? Wirral-specific analysis was then also carried out, using data from January 2017 through to July 2021 (Mental Health Services Dataset) and September 2021 (A&E attendances and hospital admissions data), to show a pre-COVID and during COVID picture of mental health among local children & young people [19].

Some notable findings were:

- This cohort of children and young people (A&E attendances and admissions), were a more deprived cohort compared to all children and young people aged 0-25 in Wirral overall
- CAMHS (or AMHS) referrals also followed a pattern consistent with deprivation (higher referrals from the more deprived areas)
- Females made up a smaller proportion of the mental health cohort than males at ages 1-11, but from age 12/13 onwards, females then comprising the majority of the cohort
- Reasons for this may include behavioural issues which affect males becoming apparent earlier in childhood than is the case in females and the large increase in A&E Attendances related to alcohol and substance misuse in females (which showed a huge increase between the ages of 13 and 14) indicating this is a key period of risk for females
- The highest rates of A&E attendances for both sexes was for substance misuse, followed by self-harm and alcohol; attendances for eating disorders were considerably lower than attendances for the other three reasons (alcohol, substance misuse and self-harm)
- **Females had higher rates of A&E attendances and hospital admissions than males for all 4 reasons (eating disorders, alcohol, substance misuse and self harm)**
- Referral rates to CAHMHS in males greatly exceeded that of females up to age 11; at age 12 however, the situation reversed, with female rates then overtaking males
- The peak age of referral to CAMHS (or AMHS) for females was 17, while for males it was age 25; overall referrals were slightly higher in males
- Contacts with CAMHS (or AMHS) followed the same pattern as referrals (broadly, males had higher referrals at younger ages, females had higher referrals during the teenage years); overall contacts were broadly equal between the sexes
- This points to the fact that although females appeared to have higher need (evidenced by A&E attendances and hospital admissions), referrals and contacts were roughly equal between the sexes, suggesting **potential unmet need in females**

The full slide-set summarising the results for the Wirral-only sample can be accessed via the Wirral Intelligence Service website here.

Mental Health in Adults

Mental health issues can affect anybody, irrespective of sex or gender identity, but it is well evidenced (nationally and locally) that men are more likely that women to commit suicide as well as having drug and dependencies.

There are however, certain risk factors that are more likely impact a women's mental health such as experiencing sexual violence, abuse (mental, physical and sexual), caring responsibilities and socio-economic status [46]; many of these issues are covered elsewhere in this briefing. There are female specific issues which affect mental health such as peri/post-natal depression and menopause.

Caring responsibilities can lead to mental health issues such as depression or stress. The most recent Survey of Adult Carers in England [47] in 2021/22 reports that a higher proportion of female carers reported feelings of depression, stress and irritability. This was the same for Wirral, (with the exception of feeling depressed) – see **Table 3**.

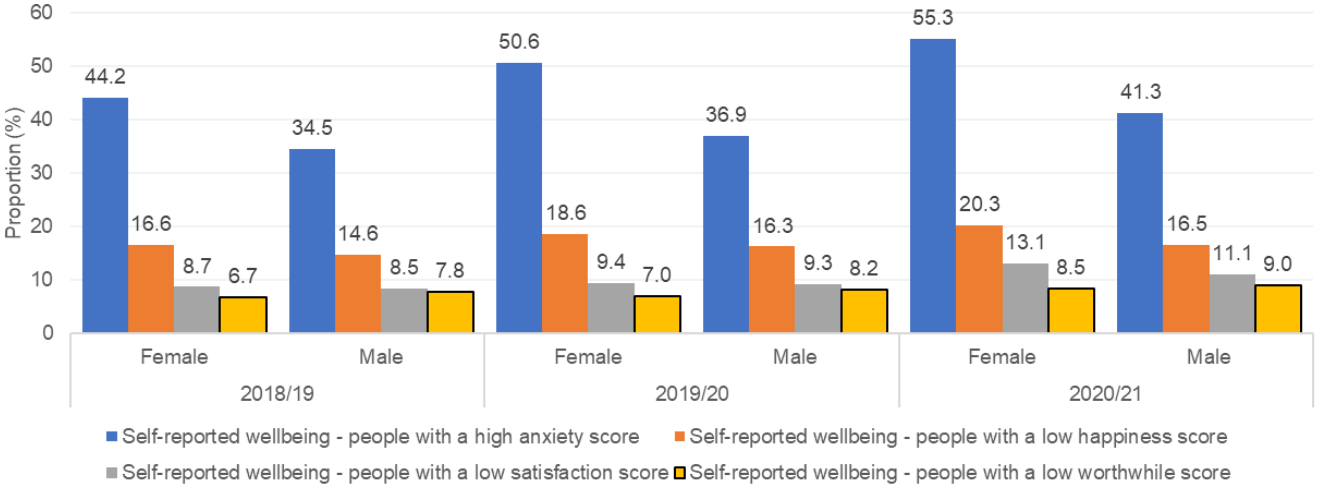
Table 3: Survey of Adult Carer Survey responses (Q14) in Wirral and England, by sex, 2021/22

Area	Sex	Feeling depressed	General feeling of stress	Short-tempered/ Irritable	Feeling tired	Disturbed sleep
Wirral	Male	42.0%	52.2%	33.3%	62.3%	56.5%
	Female	*40.6%*	*60.0%*	*42.4%*	*74.1%*	*62.4%*
England	Male	43.1%	54.1%	43.1%	72.7%	62.0%
	Female	*50.2%*	*67.8%*	*44.3%*	*81.1%*	*69.1%*

Source: Survey of Adult Carers in England 2021/22, NHS Digital (2022) [47]

Similarly, female carers were more likely to answer 'yes' to issues related to mental health (feeling tired and/or disturbed sleep) in both England and Wirral. Other self-reported wellbeing statistics show a similar pattern; females more likely to report mental health issues. The Annual Population Survey undertaken by the Office for National Statistics (ONS) records four self-reported wellbeing scores; anxiety, worthwhileness, (life) satisfaction and happiness. In three of the four, women scored lower than men – see **Figure 14**.

Figure 14: Self-reported wellbeing in England, by sex, 2018/19 to 2020/21



Source: Common Mental Disorders Profile, Office for Health Improvement and Disparities (OHID), 2022

Estimates suggest that between 10%-20% of women experience mental health problems whilst pregnant or within the first year after birth [48]. In 2019 and 2020, there were close to 6,000 births* in Wirral over the two year period, meaning that approximately 60-120 pregnant women or new mothers will likely have experienced mental health issues locally in that period.

It is worth noting that, in terms of access to mental health services, IAPT (Increasing Access to Psychological Therapies) locally fast-tracks referrals for two groups of people; one is veterans, the other is women in the peri-natal period.

Research suggests that due to longer life expectancy, women are more likely to both, outlive their partners and being admitted to residential social care [46]. This can affect the mental health of older women due to psycho-social factors such as new living arrangements, losing independence and experiencing the grief of losing a loved one.

Cancer

Wirral Cancer JSNA (2021) showed that urgent referrals fell during the early stage of the pandemic, with the reduction in referrals significantly greater amongst people living in the most deprived areas; 9% reduction in the most deprived areas, compared to a 5% reduction in the least deprived [4].

A later Cheshire & Merseyside Cancer Alliance Report (2022) [3] on cancer inequalities showed that overall, referrals had recovered by September 2020, but that the impact was still unequal in terms of age, gender, deprivation and age, specifically with, “People living in the most deprived neighbourhoods more affected than those in less deprived neighbourhoods” [3]. Notably, men were more affected than women (in terms of impact on referrals).

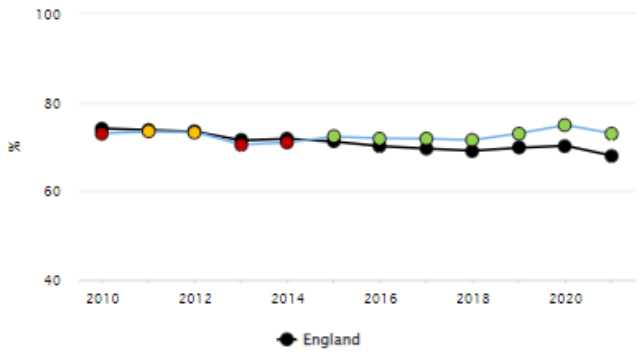
The number of patients seen following an urgent suspected cancer GP referral between April and September 2021 was 12% higher than pre-pandemic (April and September 2019). This was a larger increase than in England as a whole, where referrals rose by 9%. Wirral saw the greatest rise in referrals (23% increase) across Cheshire & Merseyside. Figures split by gender are not available for Wirral alone, but in C&M overall, referrals in females increased by 1% (compared to male referrals which had fallen by 5%) between April and September 2021.

Screening

For several months in 2020/21, the cancer screening programmes were paused in Cheshire and Merseyside due to the pandemic (as they were across England, other than for high-risk patients) [4]. Consequently, the number of new cancer patients diagnosed and referred for treatment *by the screening programmes alone* reduced by 52% in 2020/21, compared with 2019/20 [4].

As **Figure 15** shows, there was a drop in cervical screening coverage in women aged 25-49 in 2021 compared to 2020, but Wirral still had significantly higher rates than England overall (73.0% versus 68.0% in England). It should be noted that this figure is for the previous 3.5 years (rolling average), which can smooth out variation.

Figure 15: Trend in cervical screening coverage (ages 25-49, in previous 3.5 year rolling period) in Wirral and England, 2010 to 2021

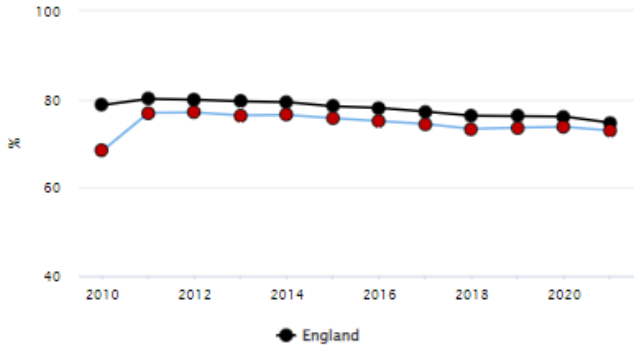


Recent trend: ⬆ Increasing & getting better

Period		Wirral Count	Value	95% Lower CI	95% Upper CI	England
2010	●	38,968	73.0%	72.6%	73.4%	74.1%*
2011	●	38,890	73.4%	73.0%	73.8%	73.7%*
2012	●	38,672	73.3%	72.9%	73.6%	73.4%*
2013	●	37,110	70.5%	70.1%	70.9%	71.5%*
2014	●	37,296	71.0%	70.6%	71.4%	71.8%*
2015	●	37,770	72.3%	71.9%	72.7%	71.2%*
2016	●	37,493	71.9%	71.6%	72.3%	70.2%*
2017	●	37,447	71.8%	71.5%	72.2%	69.6%*
2018	●	37,107	71.5%	71.1%	71.9%	69.1%*
2019	●	37,916	73.0%	72.7%	73.4%	69.8%*
2020	●	38,859	74.9%	74.5%	75.3%	70.2%*
2021	●	37,780	73.0%	72.7%	73.4%	68.0%*

Source: PHOF, OHID, 2022

Figure 16: Trend in cervical screening coverage (ages 50-64, in previous 5.5 year rolling period) in Wirral and England, 2010 to 2021



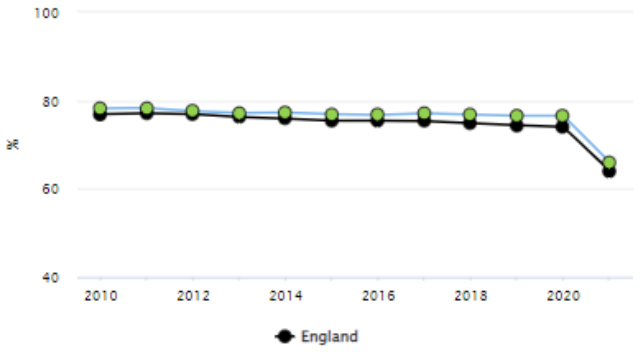
Recent trend: ⬇ Decreasing & getting worse

Period		Wirral Count	Value	95% Lower CI	95% Upper CI	England
2010	●	20,962	68.3%	67.8%	68.8%	78.7%*
2011	●	21,201	77.0%	76.5%	77.5%	80.1%*
2012	●	21,383	77.0%	76.5%	77.5%	79.9%*
2013	●	21,528	76.4%	75.9%	76.9%	79.5%*
2014	●	22,011	76.4%	75.9%	76.9%	79.4%*
2015	●	22,306	75.7%	75.2%	76.2%	78.4%*
2016	●	22,570	75.1%	74.6%	75.6%	78.0%*
2017	●	22,714	74.4%	73.9%	74.9%	77.2%*
2018	●	22,830	73.3%	72.8%	73.8%	76.2%*
2019	●	23,304	73.6%	73.1%	74.1%	76.2%*
2020	●	23,634	73.7%	73.3%	74.2%	76.1%*
2021	●	23,687	72.9%	72.4%	73.4%	74.7%*

Source: PHOF, OHID, 2022

As **Figure 16** shows, there was a slight drop in cervical screening coverage in both England and Wirral in 2021 compared to 2020, which did not alter the trend of Wirral having significantly lower rates than England overall (72.9% versus 74.7% in England). It should be noted that this figure is for the previous 5.5 years (rolling average), which can smooth out variation.

Figure 17: Trend in breast cancer screening coverage (women aged 53 to 70 in previous 36 months) in Wirral and England, 2010 to 2021



Recent trend: ⬇ Decreasing & getting worse

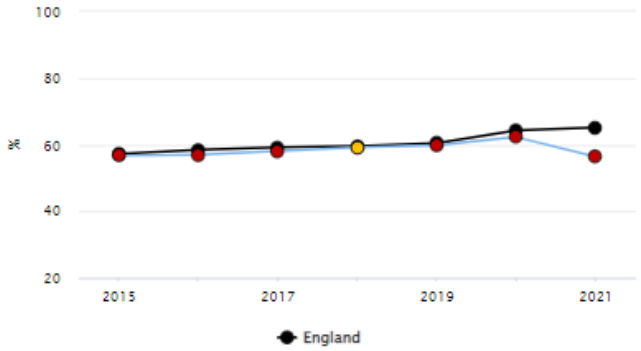
Period		Wirral Count	Value	95% Lower CI	95% Upper CI	England
2010	●	28,101	78.3%	77.8%	78.7%	76.9%
2011	●	28,434	78.3%	77.9%	78.7%	77.1%
2012	●	28,478	77.5%	77.1%	78.0%	76.9%
2013	●	28,857	77.2%	76.8%	77.6%	76.3%
2014	●	29,284	77.3%	76.9%	77.7%	75.9%
2015	●	29,529	76.9%	76.4%	77.3%	75.4%
2016	●	29,917	76.8%	76.4%	77.2%	75.5%
2017	●	30,633	77.1%	76.7%	77.6%	75.4%*
2018	●	30,650	76.8%	76.4%	77.2%	74.9%*
2019	●	30,744	76.6%	76.2%	77.0%	74.5%*
2020	●	30,882	76.6%	76.2%	77.0%	74.1%*
2021	●	26,845	66.1%	65.6%	66.5%	64.1%*

Source: PHOF, OHID, 2022

As **Figure 17** shows, there was a steep drop in breast screening coverage in 2021 compared to 2020, in both Wirral and England overall. Wirral still had significantly higher uptake rates than

England overall (66.1% versus 64.1% in England). It should be noted that this figure is for the previous 36 month period, which can smooth out variation.

Figure 18: Trend in bowel cancer screening coverage in Wirral and England, 2015 to 2021



Recent trend: ➡ No significant change

Period		Wirral Count	Value	95% Lower CI	95% Upper CI	England
2015	●	31,590	56.7%	56.3%	57.1%	57.3%*
2016	●	32,191	57.0%	56.6%	57.4%	58.4%*
2017	●	33,273	58.1%	57.7%	58.5%	59.2%*
2018	●	34,354	59.2%	58.8%	59.6%	59.5%*
2019	●	35,253	59.8%	59.4%	60.2%	60.5%*
2020	●	37,176	62.2%	61.8%	62.6%	64.2%*
2021	●	34,267	56.3%	55.9%	56.7%	65.2%*

Source: NHS Digital data not in the public domain, from the Bowel Screening Programme

Source: PHOF, OHID, 2022

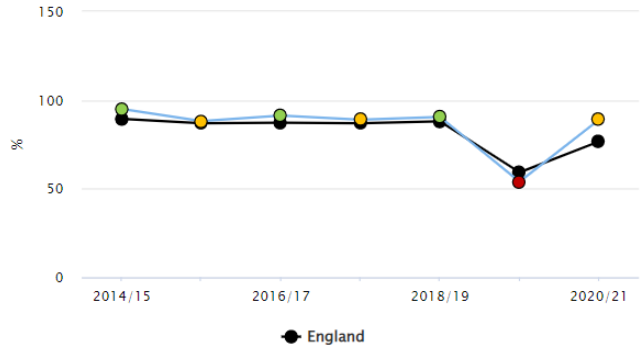
Published bowel cancer screening programme data is not spilt by gender, therefore it is unknown if women are more or less likely than men to be screened, **Figure 18** above shows all persons. As the chart shows, uptake in Wirral dropped sharply in 2021 to its lowest rate in the time period shown and in contrast to England (where uptake actually increased). Reasons for this are unclear.

Nationally, although OHID do not publish data by gender, data is published showing uptake by deprivation decile. Uptake in 2020 was 57.6% in Decile 1 (Most Deprived), versus 66.1% in Decile 10 (Least Deprived).

HPV (Human Papillomavirus) vaccination

The HPV national vaccination programme was introduced in 2008 to protect adolescent females against cervical cancer. At the time, a 3-dose schedule was offered routinely to secondary school Year 8 females (aged 12 to 13) alongside a catch-up programme targeting females aged 13 to 18. In September 2014, the programme changed to a 2-dose schedule based on evidence that showed that 2 doses were as good as 3 doses. From September 2019, 12 to 13 year old males became eligible for HPV immunisation alongside females, based on Joint Committee on Vaccination and Immunisation (JCVI) advice [9].

Figure 19: Trend in rate of HPV vaccination coverage (one dose, 12-13 year olds)



Recent trend: ⬇ Decreasing & getting worse

Benchmarking against goal: <80% | 80% to 90% | ≥90%

Period		Wirral Count	Value	95% Lower CI	95% Upper CI	North West	England
2014/15	●	1,649	94.9%	93.8%	95.9%	91.2%	89.4%
2015/16	●	1,612	88.2%	86.6%	89.6%	88.2%	87.0%
2016/17	●	1,697	91.3%	90.0%	92.5%	88.5%	87.2%
2017/18	●	1,665	89.0%	87.5%	90.3%	87.2%	86.9%
2018/19	●	1,685	90.5%	89.1%	91.7%	88.4%	88.0%
2019/20	●	975	53.9%	51.6%	56.2%	68.4%	59.2%
2020/21	●	1,751	89.0%	87.5%	90.3%	79.5%	76.7%

Source: PHOF, OHID, 2022

As **Figure 19** shows, in 2019/20 when COVID-19 caused the HPV programme in schools to cease, vaccination plummeted in Wirral from 90.5% to 53.9% coverage. By 2020/21, rates had almost recovered and were 89.0%.

Health impacts of violence against women and girls

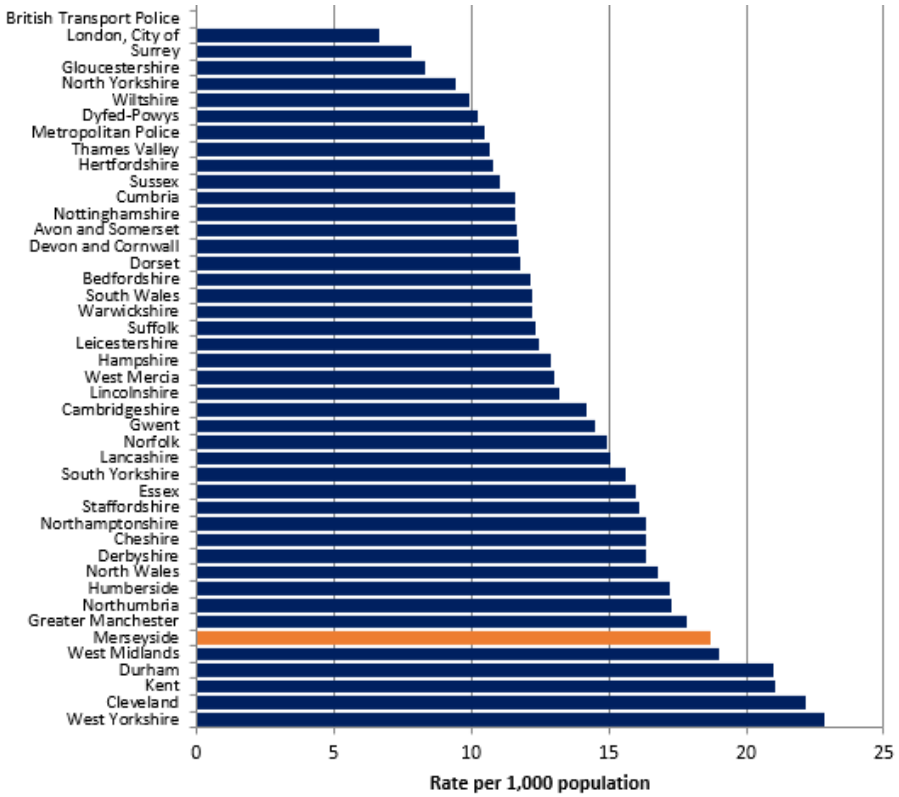
Domestic Abuse

Published data from England's Police forces does not distinguish between male and female victims, so most of the information below from Merseyside Police is for both sexes. It is also not possible to split Merseyside Police data by Local Authority, so data is presented for the whole of Merseyside and does not relate to Wirral overall.

In Merseyside, 6% of cases discussed at MARACs (Multi-Agency Risk Assessment Conferences) in 2020/21 involved a male victim; 94% involved a female victim [7]. In Merseyside, 38% of cases discussed at MARACs in the year ending March 2021 were repeat cases [7].

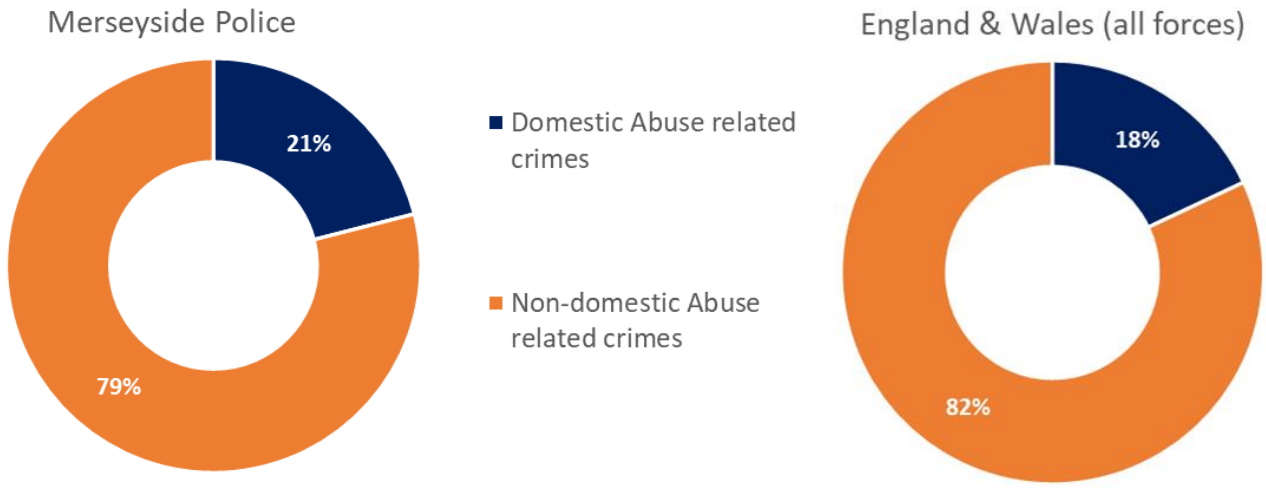
Figure 20 below shows the rate of domestic abuse-related crimes recorded by the police in 2020/21. As the chart shows, Merseyside Police had one of the highest rates of domestic abuse related crime in England and Wales in 2020/21. In actual numbers, there were 26,789 domestic abuse-related crimes were recorded in Merseyside in 2020/21; this is equivalent to 19 crimes for every 1,000 people in the population.

Figure 20: Rate of domestic abuse related crimes recorded by the police, Merseyside Police and all other English police forces, 2020/21



Source: ONS, Domestic Abuse Statistics Data Tool, 2022

Figure 21: Proportion of *all* crime recorded by police which were flagged as domestic abuse related, Merseyside Police and England & Wales (all forces), 2020/21

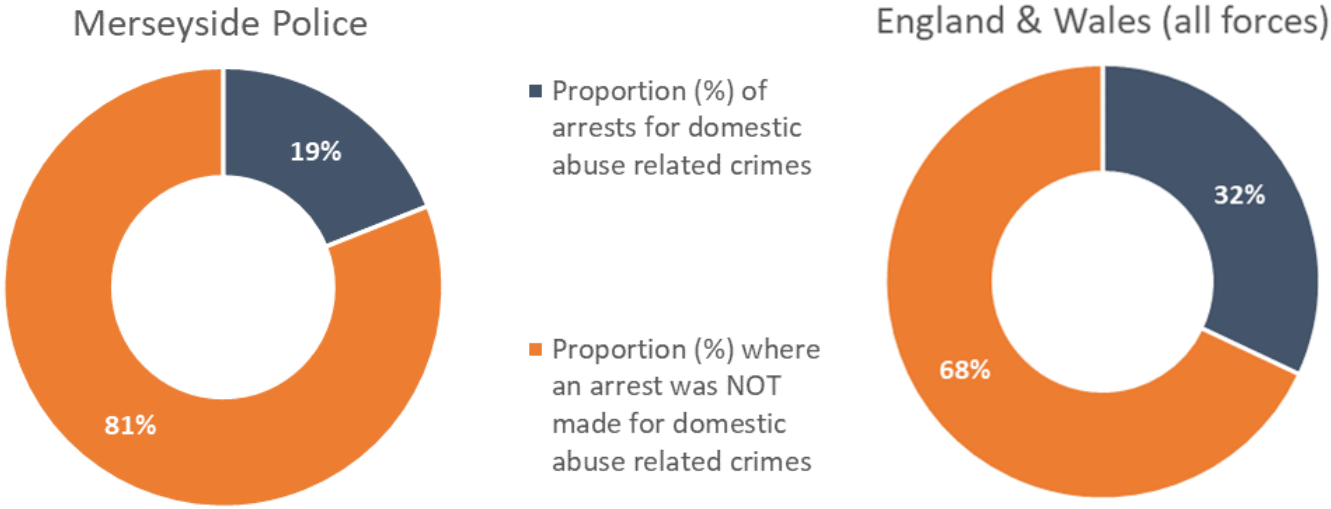


Source: ONS, Domestic Abuse Statistics Data Tool, 2022

As **Figure 21** above shows, a slightly higher (21%) of all crimes recorded by police were flagged as domestic abuse related in Merseyside, compared to England and Wales overall (18%) in 2020/21 [8].

As **Figure 22** below shows that 19% of all domestic abuse related crimes resulted in an arrest in Merseyside in 2020/21, compared to 32% in England and Wales overall [8].

Figure 22: Proportion of arrests (%) for domestic abuse related crimes in Merseyside Police and England & Wales overall (all forces), 2020/21



Source: ONS, Domestic Abuse Statistics Data Tool, 2022

Sexual abuse

Research shows that both male and female victims of abuse have significantly higher rates of psychiatric problems than the general population. Studies demonstrate an association between child sexual abuse and subsequent rates of childhood and adult mental disorders [21].

The Crime Survey for England and Wales (CSEW) estimated that 7.5% of adults aged 18 to 74 years experienced sexual abuse before the age of 16 years; with women around three times as likely as men to have experienced sexual abuse before the age of 16 years (11.5% compared with 3.5%) [31].

Table 4: Estimated number of people aged 18-74 predicted to be survivors of childhood sexual abuse in Wirral, by sex

	Males	Females	Persons
Number	3,800	13,260	17,060
Percentage	3.5%	11.5%	7.5%

Source: Crime Survey for England & Wales, 2019 (ONS, 2020). Percentages applied to the 2020 Md-Year population estimates for Wirral.

As **Table 4** above shows, the proportion of females who report having been sexually abused in childhood is more than three times the proportion for males (11.5% compared to 3.5% of males), meaning there could be over 13,000 women aged 18-74 living in Wirral who are survivors of childhood sexual abuse.

ONS note that females accounted for the majority of victims of sexual offences against children as recorded by the police in the year ending March 2019 (80% female, 20% male) and girls were around twice as likely as boys to be subject to a child protection plan for sexual abuse in England (2 in 10,000 girls compared with 1 in 10,000 boys) [31].

Data from other services confirm these findings; Childline data for example, shows that the majority of counselling sessions are with girls, the most common age was 15 years and of the counselling sessions provided for sexual abuse in the year ending March 2019, (where gender was known), 87% were delivered to females [31]. Around three-quarters of sexual abuse-related calls to the National Association for People Abused in Childhood's (NAPAC's) helpline in the same year were from females (75%) [31].

'Honour' based abuse (including Female Genital Mutilation or FGM and forced marriage)

Information on the number of police recorded offences which were identified as being so called 'honour-based' abuse (HBA) related have been collected by the Home Office (HO) from police forces on a mandatory basis since April 2019 [30]. So called HBA-related crime is defined by the police and Crown Prosecution Service as:

> *"An incident or crime involving violence, threats of violence, intimidation, coercion or abuse (including psychological, physical, sexual, financial or emotional abuse) which has or may have been committed to protect or defend the honour of an individual, family and/or community for alleged or perceived breaches of the family and/or community's code of behaviour".*

This data (which is published by ONS) includes, but is not limited to, crimes of forced marriage and female genital mutilation (FGM). For a definition of FGM, please see the Glossary. The data also identifies the number of FGM offences that have been reported to and recorded by the police following a referral via the FGM Mandatory Reporting Duty (the requirement for regulated health and social care professionals and teachers in England and Wales to report known cases of FGM in under 18-year-olds to the police came into force on 31 October 2015) [30].

As with all police recorded crime figures, these data only cover crimes that were reported to and recorded by the police. It is recognised that victims of HBA can be reluctant to bring them to the attention of police or other authorities, meaning this data is likely to represent a small proportion of the actual HBA offences committed. The Home Office are aware of data quality issues with HBA data, for example, in some police forces, the identification of crimes as HBA-related relies

on a police officer or other member of police staff remembering to correctly apply the HBA-related identifier to an offence on their Record Management System. The Home Office acknowledge that these identifiers are not always correctly applied and their statisticians continue to work with police forces to improve the quality of HBA data [30]. Therefore, the data is labelled as experimental statistics (a designation used for newly developed or innovative official statistics that are still undergoing evaluation) [30].

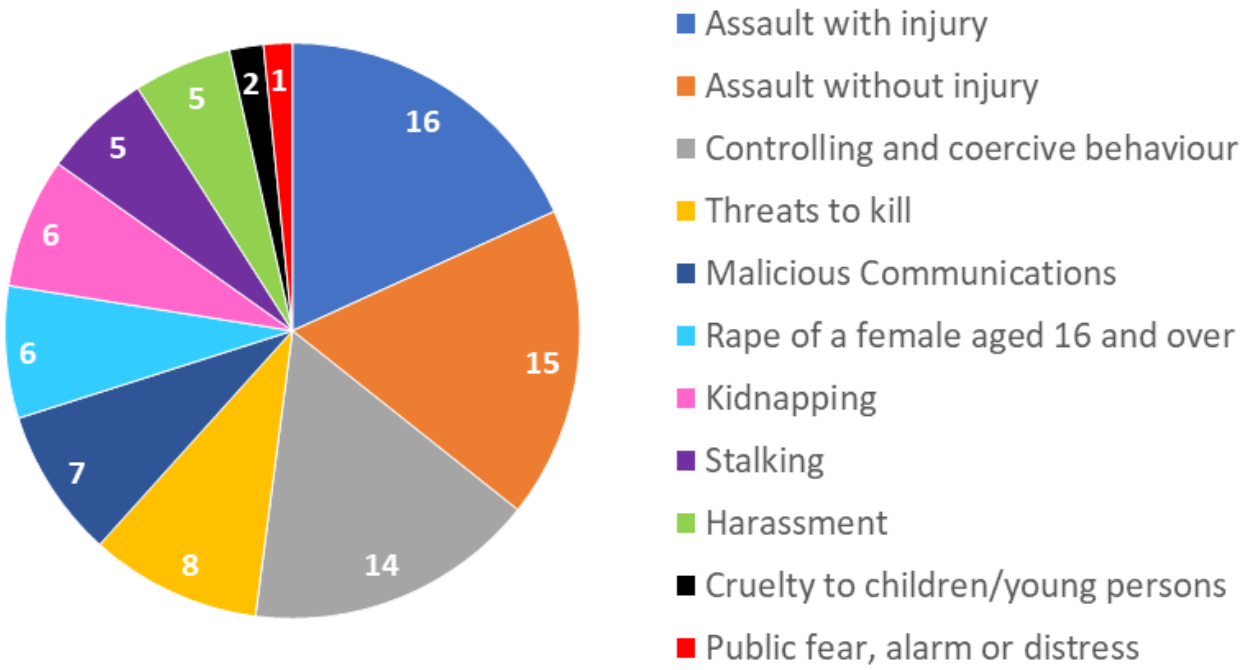
Table 5: Offences involving so called 'honour-based' abuse recorded by the police in England and Wales, 2020/21

	FGM offences	Forced marriage offences	Other HBA-related offences	All HBA-related offences
England & Wales	78	125	2,522	**2,725**

Source: Police recorded crime, Home Office

Of the total of 2,725 total offences recorded in England & Wales inn 2020/21, the highest number were recorded in the North-West region (n=437). Of the 5 forces which comprise the North-West region (in police terms), Greater Manchester Police recorded the highest number, with 342, while Cumbria Police recorded none. Merseyside Police recorded 29 offences. As noted above however, there are data quality issues with information from some police forces.

Figure 23: 'Honour-based' abuse offences by offence category (%) England and Wales, 2020/21



Source: Police recorded crime, Home Office (breakdown by individual Police Forces unavailable)

Healthy ageing and long term conditions

Living alone

Living alone is not always experienced negatively, but it can be a risk factor for social isolation and loneliness. Although neither social isolation or loneliness are limited to older people or older women (they can be experienced at any age), living alone is one of several risk factors which

make it more likely to occur in older age (along with bereavement, reduced income following retirement, poor physical health etc..). This puts older people – and particularly older women - at higher risk as they are more likely to be living alone than men of the same age. **Table x** below shows the number of older people in Wirral estimated to be living alone in 2020, by sex.

Table 6: Estimated number of people aged 65+ living alone in Wirral in 2020, by sex

	Males	Females	Persons
Number aged 65-74	3,700	5,800	9,500
Number aged 75+	4,060	9,700	13,760
Total	**7,760**	**15,800**	**23,260**

Source: POPPI, 2022

As **Table 6** above shows, there were estimated to be more than double the number of older women living alone, compared to men in Wirral in 2020. At age 75+, an estimated 29% of men live alone (just under 1 in 3), compared to 50% of women (half or 1 in 2).

Alcohol

Among people aged 15 to 49, alcohol is the leading cause of ill-health, disability, and death in England [39]. Alcohol misuse is a significant public health problem with major health, social and economic consequences, estimated at between £21 and £52 billion a year [39].

Alcohol has a wide range of health impacts including cardiovascular disease, cancers (breast, bowel, throat and mouth) and FASD (foetal alcohol spectrum disorder) [39]. Harmful use of alcohol contributes not only to the burden of non-communicable diseases (NCDs), but also to the burden of communicable diseases, as well as violence and injuries [39].

The UK Chief Medical Officer (CMO) advises that adults should drink no more than 14 units of alcohol per week; adults aged 45-64 were most likely to exceed this weekly limit, with 37% of men and 19% of women drinking 14+ units per week [40]. Over half (54%) of adults In England reported drinking alcohol in the last week and although men are slightly more likely to drink than women (59% of men vs 50% of women drank alcohol during the previous week), crucially, women remain more vulnerable to the impacts of alcohol at lower levels of consumption [41].

This is because women's bodies are affected differently by alcohol, for reasons that go beyond size [41]. Women produce smaller quantities of the enzyme alcohol dehydrogenase (ADH), which is released in the liver and breaks down alcohol in the body. In addition, because fat retains alcohol, while water helps disperse it (and as women have naturally higher levels of body fat and lower levels of water), women experience a more dramatic physiological response to alcohol [41]. This is why women experience increased medical issues with alcohol-use disorders, compared to men; women who drink excessively also tend to develop addiction and other medical issues more quickly than men [41]. It's a phenomenon known as 'telescoping': women with alcohol issues often start drinking later in life than men, but alcohol addiction develops more quickly, as does liver disease and damage to the heart and nerves [41]. Many of these gender-based differences in alcohol's effects on the body were not discovered until quite recently; the earliest study on gender-based differences in ADH, for example, was published in 1990 [41].

In fact, almost all clinical studies on alcohol were done ***only*** on men until the 1990s [41]. This was partly because scientists were encouraged to eliminate as many variables as possible that

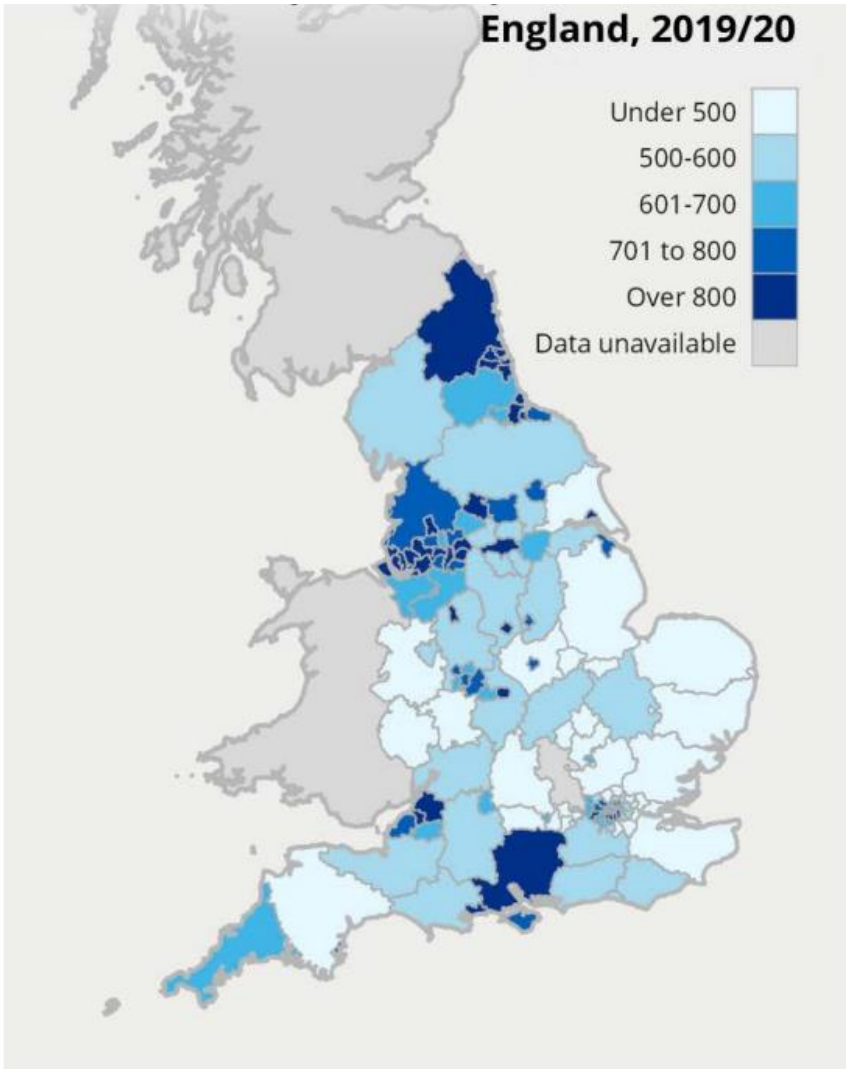
might bias results – one of which was gender - and also because alcoholism was assumed to predominantly a male issue [41]. Evidence also suggests that women are less likely, over the lifetime, to enter treatment compared to males and have better outcomes when they're in women-only treatment groups that also educate about the gender-specific elements of their addiction and women's motivations for drinking [41, 42]. Perhaps unsurprisingly, those motivations have been found to differ from men's, with research showing women's drinking is tied to more often to quelling emotional pain, while men's drinking is more tied to social pressure [41].

Each year there are over 1 million admissions to hospital for alcohol-related conditions for example, with Wirral identified as one of the top 10 authorities in the country for alcohol admissions, see **Box 3** below.

Box 3: Alcohol Specific Hospital Admission Rates in England, 2019/20 (rate per 100,000)

10 HIGHEST RATES	
Southampton	2,590
Salford	1,613
Liverpool	1,360
Blackpool	1,359
Wirral	1,231
South Tyneside	1,229
Sefton	1,187
Bristol	1,182
Newcastle upon Tyne	1,177
Hartlepool	1,171

10 LOWEST RATES	
Redbridge	331
Thurrock	345
Wokingham	349
Barnet	376
Essex	377
Bromley	384
Medway	388
West Berkshire	391
Rutland	396
Lincolnshire	402



Source: Alcohol Statistics, House of Commons Briefing [40]

As **Table 7** below shows, on the vast majority of outcomes related to alcohol recorded by OHID, women in Wirral perform significantly worse than England; these are long-standing trends.

Table 7: Alcohol Indicators (female specific) for Wirral

Indicator	Period	Wirral			Region	England		England
		Recent Trend	Count	Value	Value	Value	Worst	Range
Admission episodes for alcohol-related cardiovascular disease (Broad): New method. This indicator uses a new set of attributable fractions, and so differ from that originally published. (Female, All ages)	2020/21	→	395	204	199	180	277	
Admission episodes for alcohol-related conditions (Broad): New method. This indicator uses a new set of attributable fractions, and so differ from that originally published. (Female, All ages)	2020/21	→	1,912	1,122	936	805	1,923	
Admission episodes for alcohol-related conditions (Narrow) - Under 40s: New method. This indicator uses a new set of attributable fractions, and so differ from that originally published. (Female, <40 yrs)	2020/21	→	205	303.8	174.8	144.2	363.2	
Admission episodes for alcohol-related conditions (Narrow) – 65+ years: New method. This indicator uses a new set of attributable fractions, and so differ from that originally published. (Female, 65+ yrs)	2020/21	→	103	272	311	352	601	
Admission episodes for alcohol-related unintentional injuries (Narrow): New method. This indicator uses a new set of attributable fractions, and so differ from that originally published. (Female, All ages)	2020/21	→	28	16.6	13.6	10.9	22.1	
Admission episodes for alcohol-specific conditions (Female, All ages)	2020/21	→	1,190	730	535	380	1,286	
Admission episodes for alcohol-specific conditions - Under 18s (Female, <18 yrs)	2018/19 - 20/21	–	55	55.9	51.0	36.1	111.3	
Admission episodes for alcoholic liver disease (Broad): New method. This indicator uses a new set of attributable fractions, and so differ from that originally published. (Female, All ages)	2020/21	→	204	123.1	113.7	83.4	195.8	
Admission episodes for intentional self-poisoning by and exposure to alcohol (Narrow): New method. This indicator uses a new set of attributable fractions, and so differ from that originally published. (Female, All ages)	2020/21	→	178	119.3	64.4	51.1	156.1	
Admission episodes for mental and behavioural disorders due to use of alcohol (Broad): New method. This indicator uses a new set of attributable fractions, and so differ from that originally published. (Female, All ages)	2020/21	→	735	441	323	222	1,042	
Admission episodes for mental and behavioural disorders due to use of alcohol (Narrow): New method. This indicator uses a new set of attributable fractions, and so differ from that originally published. (Female, All ages)	2020/21	→	155	97.6	62.5	41.1	127.9	
Alcohol-related mortality: New method. This indicator uses a new set of attributable fractions, and so differ from that originally published. (Female, All ages)	2020	→	49	27.2	25.4	20.9	40.5	
Alcohol-specific mortality (Female, All ages)	2017 - 19	–	59	11.5	10.1	7.1	17.3	
Hospital admission rate for alcoholic liver disease (Female, All ages)	2020/21	→	65	42.9	42.9	30.1*	89.2	
Incidence rate of alcohol-related cancer (Female, 16+ yrs)	2017 - 19	–	225	40.67	38.32	37.09	42.33	
Potential years of life lost (PYLL) due to alcohol-related conditions (Female, All ages)	2020	→	1,197	722	640	500	1,125	
Admission episodes for alcohol-related conditions (Narrow) – 40 to 64 years: New method. This indicator uses a new set of attributable fractions, and so differ from that originally published. (Female, 40-64 yrs)	2020/21	→	346	628	547	554	1,092	
Admission episodes for alcohol-related conditions (Narrow): New method. This indicator uses a new set of attributable fractions, and so differ from that originally published. (Female, All ages)	2020/21	→	654	406	326	322	597	
Under 75 mortality rate from alcoholic liver disease (Female, <75 yrs)	2017 - 19	–	46	10.1	9.8	6.5	16.6	

Source: PHOF, OHID, 2022

Coronary Heart Disease (CHD)

CHD kills twice as many women as breast cancer in the UK, however, there are still misperceptions that it's more of an issue for males [38]. This can mean that women are less likely to recognise they are having a heart attack, leading them to delay seeking help [38]. Women typically arrive at hospital later than men when having a heart attack - and the longer treatment for a heart attack is delayed, the greater the chance of permanent damage to the heart [38].

Systematic review found that the average (median) delay between the onset of symptoms and arrival at hospital for men ranges between 1 hour 24 minutes and 3 hours 30 minutes. For women the delay ranged between 1 hour 48 minutes and 7 hours 12 minutes [38]. In addition, people who receive an incorrect initial diagnosis of heart attack have a 70% higher risk of death after 30 days compared to someone who receives the correct diagnosis straightaway; woman are 50% more likely than a man to receive the wrong initial diagnosis for a heart attack according to a study which looked at UK data between 2002 and 2013 [38].

Women, on average, have heart attacks 7-10 years later than men (younger women are thought to be protected by oestrogen, menopause therefore increases the risk of heart attack), but it is still the case that younger women can (and do) have heart attacks - and when they do, they can be even more disadvantaged, e.g. by having their symptoms attributed to another cause without proper exploration and receive fewer evidence-based treatments than their male counterparts [38]. Younger women can also experience an entirely different type of heart attack, caused by

spontaneous coronary artery dissection (SCAD). It's rare, but predominantly affects young, otherwise healthy women. The average age of a person having a SCAD is 42 and women make up 80% of people with SCAD, which can also be associated with pregnancy [38].

Women with pregnancy complications such as pre-eclampsia, gestational diabetes, pre-term delivery, multiple pregnancies or miscarriage are at higher risk of developing heart and circulatory diseases later in life [38]. This is because pregnancy puts unique stresses on the heart and circulation – the amount of blood circulating increases by 50%, and the way the body processes fat and sugar changes, it is for these reasons, cardiologists often describe pregnancy as a heart and circulatory 'stress test' [38]. The BHF (British Heart Foundation) maintain that women should be screened for heart disease risk factors during their pregnancy and after birth [38].

It is also the case that women who have similar risk factors to men have a greater chance of developing CHD; a lack of awareness of this so-called 'excess risk' means that women often dramatically underestimate their personal risk of heart attack [38]. For example, while male smokers have more than double the heart attack risk of men who have never smoked, female smokers have over three times the risk of women who have never smoked [38]. In addition, women who have established CHD are less likely than men to reduce the chances of a further heart attack by managing their risk factors [38]. **Table 8** below, shows how Wirral performs on a number indicators for premature mortality from heart (and circulatory) disease, by sex (premature mortality is deaths before the age of 75).

Table 8: Premature mortality indicators for CHD and CVD in Wirral, by sex

Indicator	Period	Wirral			Region	England	England	
		Recent Trend	Count	Value	Value	Value	Worst	Range
Under 75 mortality rate from all cardiovascular diseases								
Under 75 mortality rate from all cardiovascular diseases (Persons, 3 year range)	2017 - 19	–	680	71.6	86.1	70.4	121.6	
Under 75 mortality rate from all cardiovascular diseases (Male, 3 year range)	2017 - 19	–	455	100.1	119.0	98.9	165.6	
Under 75 mortality rate from all cardiovascular diseases (Female, 3 year range)	2017 - 19	–	225	45.2	54.5	43.4	78.1	
Under 75 mortality rate from all cardiovascular diseases (Persons, 1 year range)	2020	➡	285	89.0	90.5	73.8	137.1	
Under 75 mortality rate from all cardiovascular diseases (Male, 1 year range)	2020	➡	189	122.5	129.2	104.7	208.7	
Under 75 mortality rate from all cardiovascular diseases (Female, 1 year range)	2020	➡	96	58.1	53.6	44.6	87.4	
Under 75 mortality rate from heart disease								
Under 75 mortality rate from heart disease (Persons, 3 year range)	2017 - 19	–	357	37.4	48.6	37.5	75.4	
Under 75 mortality rate from heart disease (Male, 3 year range)	2017 - 19	–	265	58.0	73.7	58.5	107.9	
Under 75 mortality rate from heart disease (Female, 3 year range)	2017 - 19	–	92	18.4	24.6	17.5	46.0	
Under 75 mortality rate from heart disease (Persons, 1 year range)	2020	➡	148	45.8	50.4	39.1	79.5	
Under 75 mortality rate from heart disease (Male, 1 year range)	2020	➡	113	73.3	79.2	61.6	120.8	
Under 75 mortality rate from heart disease (Female, 1 year range)	2020	➡	35	20.5	22.9	17.7	45.1	
Under 75 mortality rate from stroke								
Under 75 mortality rate from stroke (Persons, 3 year range)	2017 - 19	–	137	14.3	15.0	12.3	21.6	
Under 75 mortality rate from stroke (Male, 3 year range)	2017 - 19	–	66	14.4	17.5	14.4	26.0	
Under 75 mortality rate from stroke (Female, 3 year range)	2017 - 19	–	71	14.3	12.5	10.2	18.7	
Under 75 mortality rate from stroke (Persons, 1 year range)	2020	➡	59	18.5	15.7	12.6	23.0	
Under 75 mortality rate from stroke (Male, 1 year range)	2020	➡	29	18.3	19.3	14.6	32.2	
Under 75 mortality rate from stroke (Female, 1 year range)	2020	➡	30	18.6	12.3	10.6	-	*Insufficient number of values for a spine chart*

Source: PHOF, OHID, 2022

Osteoporosis and bone health

Osteoporosis is a disease characterised by low bone mass and structural deterioration of bone tissue, with a consequent increase in bone fragility and susceptibility to fracture [36]. It is a condition which is asymptomatic and often remains undiagnosed until a fragility fracture occurs [36]. A fragility fracture is defined as a fracture following a fall from standing height or less and characteristically occurs in the wrist, spine, and hip [36].

In England and Wales, it is estimated that annually around 180,000 fractures occur as a result of osteoporosis [36]. Although osteoporosis can affect men, women are at greater risk of osteoporosis due to the decrease in oestrogen production at the menopause, which accelerates bone loss and prevalence increases markedly with age, from approximately 2% at 50 years of age to almost 50% at 80 years of age [36]. Risk factors for osteoporosis include:

- Female sex
- Increasing age
- Oral corticosteroids
- Menopause
- Smoking
- Alcohol

If these estimates by NICE are applied to the Wirral population of women aged 80+ in 2021 (Mid Year Population Estimates), this equates to around 5,900 women who will have osteoporosis, most of whom will be undiagnosed and unaware that they have the condition.

Falls and fractures

Falls and fractures in older people are often preventable and reducing them is important for maintaining the health, wellbeing and independence of older people [37]. Falls result from the presence of risk factors (muscle weakness, poor balance, visual impairment, polypharmacy – and the use of certain medicines, environmental hazards and some specific medical conditions), all of which become more common in older age [37].

The likelihood and severity of injury resulting from a fall is related to a number of factors including bone health (osteoporosis) frailty and low weight – all of which are more prevalent in women. Hip fracture in particular, is associated with increased morbidity and mortality after the event, so understanding who is likely to fall and targeting them for prevention is extremely important.

In 2020/21, over 56,000 people fractured their hip in England; the majority (71% or almost 40,000) were women. In Wirral in 2020/21, there were 610 people who fractured their hip; 265 of them (71%) were women, compared to 110 men (29%). The short and long-term outlooks for patients are generally poor following a hip fracture, with an increased one-year mortality of between 18% and 33% and negative effects on daily living activities such as shopping and walking [37]. A review of long-term disability found that around 20% of hip fracture patients entered long-term care in their first year after a fracture [37].

Pelvic floor disorders and continence

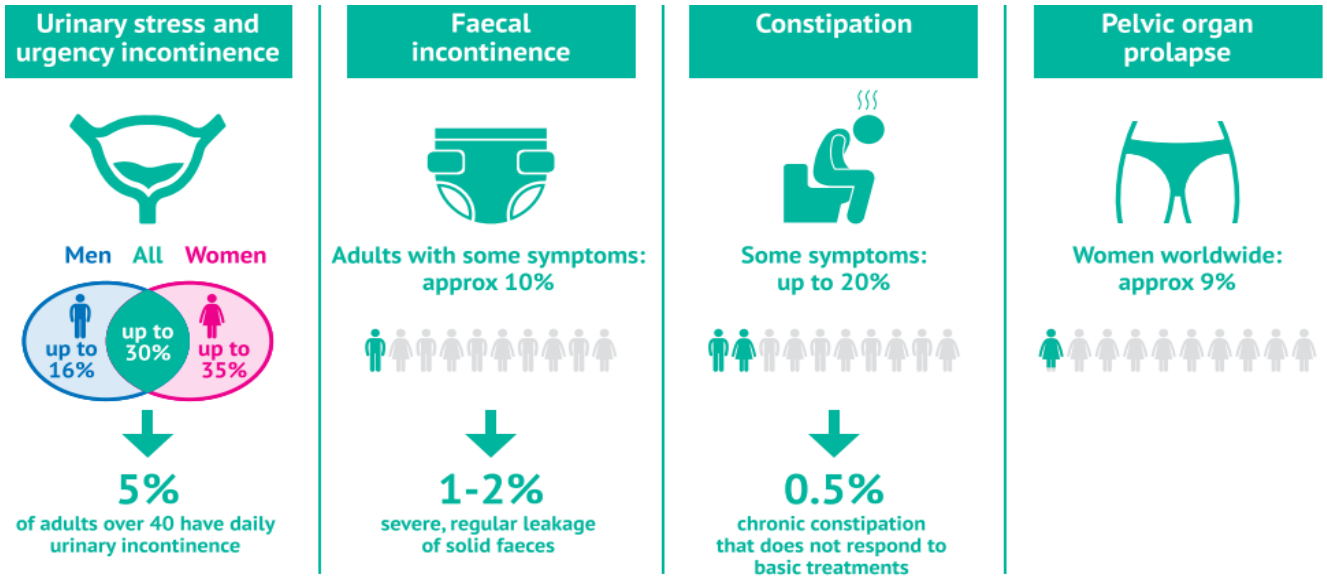
Incontinence has been named by older people as second only to dementia as their top fear related to ageing and is associated with social isolation and withdrawal (as people fear the shame of being ‘caught short’ whilst out and about) [33]. It is also associated with negative health outcomes such as cystitis, dehydration (due to limiting fluid intake), UTIs (urinary tract infections), pressure sores, rashes, falls (e.g. due to toilet visits at night) and a lack of physical activity [5]. Practical inconveniences associated with the condition, such as frequent changes of clothes and bed linen, the need to bathe more often and having to re-organise the home environment can also negatively impact quality of life [34,35].

The research and professional approach stress its treatability (and even reversibility in many cases), but lay beliefs still tend to characterise the condition as an inevitable part of ageing or an expected consequence of childbirth that just has to be endured, which is part of the reason that only 30% of people with continence issues ever seek help or treatment [24, 33]. The Pelvic Floor Society (PFS) note that it is not only stigma and shame which dissuades people from seeking medical help, but fear of surgical interventions or finding that their condition is not taken seriously

by health professionals (who may not understand the emotional impact) [24]. The PFS considers a lack of education on incontinence and awareness of the availability of treatment options, among both patients and health professionals, is contributing to the issue with the result that patients often wait for years to report their problem and once they do so, their pathway to treatment is complex – leading to years of unnecessary suffering for thousands [24].

Box 4 below provides the estimated prevalence of the main pelvic floor disorders in the UK [24], although it is important to note that prevalence of continence issues rises sharply with age, and around half of care home residents have issues.

Box 4: Prevalence of main pelvic floor disorders in the UK population



Source: Pelvic Floor Society, 2022 [24]

Tables 9 and **10** below show the proportion and number of older people estimated to be have continence issues in Wirral (estimated by POPPI using responses to the Health Survey for England, extrapolated to the Wirral population). As the tables show, a higher proportion (and number) of women are likely to be experiencing continence issues compared to men in Wirral.

Table 9: Estimated *proportion* of older people with continence issues in Wirral in 2020, by sex

Age	Females		Males	
	% less than once per week	% at least once per week	% less than once per week	% at least once per week
65-69	5%	14%	5%	12%
70-74	6%	12%	5%	15%
75-79	8%	17%	5%	18%
80-84	8%	17%	6%	21%
85+	6%	28%	13%	19%

Source: POPPI, 2022 (using figures from Health Survey for England, prevalence and frequency of bladder problems by age, sex)

Table 10: Estimated *number* of older people with continence issues in Wirral in 2020, by sex

Age	Females		Males	
	No. less than once per week	No. at least once per week	No. less than once per week	No. at least once per week
65+	1,195	6,582	1,119	5,181

Source: POPPI, 2022 (using figures from Health Survey for England, prevalence and frequency of bladder problems by age, sex)

Key gaps in knowledge and services

- Data on menopause (other than HRT prescriptions)
- Police data does not separate out either sex or Local Authorities, it is only available at Police Force level, so Domestic Abuse data is limited
- A breakdown of HPV coverage data is lacking; only a gender split is available, so we are unaware if there is a relationship between HPV vaccination and deprivation for example
- Key information about many of the inclusion health groups identified by the CORE20PLUS5 strategy is often lacking altogether or incomplete. These groups include: people experiencing homelessness, drug and alcohol dependence, vulnerable migrants, Gypsy, Roma and Traveller communities, sex workers, people in contact with the justice system, victims of modern slavery and other socially excluded groups.

Glossary

FGM: Female genital mutilation is a procedure where the female genitals are deliberately cut, injured or changed when there is no medical reason for this to be done. It's also known as female circumcision or cutting (and by other terms such as Sunna, gudniin, halalays, tahur, megrez and khitan among others). It is usually carried out on young girls between infancy and the age of 15, most commonly before puberty starts. It is illegal in the UK and is classified as child abuse. There are 4 main types of FGM:

- Type 1 (clitoridectomy) – removing part or all of the clitoris
- Type 2 (excision) – removing part or all of the clitoris and the inner labia (the lips that surround the vagina), with or without removal of the labia majora (the larger outer lips)
- Type 3 (infibulation) – narrowing the vaginal opening by creating a seal, formed by cutting and repositioning the labia
- Other harmful procedures to the female genitals, including pricking, piercing, cutting, scraping or burning the area

Menopause: A biological stage in a woman's life that occurs when she stops menstruating and reaches the end of her natural reproductive life; defined as having occurred when a woman has not had a period for 12 consecutive months (for women reaching menopause naturally)

Menopausal: Includes women in perimenopause and postmenopause

Perimenopause: The time in which a woman has irregular cycles of ovulation and menstruation leading up to menopause and continuing until 12 months after her final period. The perimenopause is also known as the menopausal transition or climacteric

Post-menopause: The time after menopause has occurred, starting when a woman has not had a period for 12 consecutive months

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