Wirral

Health Inequalities Plan

April 2009

Health Inequalities Plan

1. Introduction

Wirral Strategic Partnership has made a commitment to reduce inequalities in health and well-being. This is well documented throughout the Local Area Agreement and Sustainable Communities Strategy. In order to accelerate achievement, priority actions have been identified and agreed, with support from the National Support Team for health inequalities.

The 2010 target to reduce the gap in health inequalities between Wirral and the rest of England, provides a focus for the short term. However, sustained improvements in health and well-being also need to be realised amongst those who consistently have below average outcomes. Therefore, actions also need to be set in place now, to have an impact in the medium and longer term.

This Health Inequalities Plan sets three timescales for action:

- December 2011 – to achieve the 2010 life expectancy target for Wirral. This is measured through 3 year rolled deaths data and takes account of all deaths up to December 2011. Actions within the plan will also support achievement of Wirral's Local Area Agreement
- March 2013 – to support the NHS Wirral Strategic Plan which sets additional targets for improvements in health and well-being for those living in the most disadvantaged areas compared to the rest of Wirral
- March 2025 – to set in place actions to achieve the medium and longer term aspirations of partners documented in Wirral Sustainable Communities Strategy

Health and social care partners have a key role in leading the delivery of interventions to meet the 2011 target. In order to continue to reduce the inequalities gap in Wirral over the longer term, wider determinants need to be addressed such as education, employment and the health of children and families.

Three overarching health outcomes have been identified to demonstrate progress in reducing health and well-being inequalities. Baselines will be established and monitored for each. There are five strategic objectives, each with an action plan detailing who is responsible for ensuring its delivery and within what timescale. This will ensure co-ordinated implementation and facilitate reporting to the health and well-being Partnership Co-ordination group, through an executive lead group.

2. What are Health Inequalities

'Health inequalities' is the term used to describe the difference in health and health outcomes for different groups in the population. This relates to the quality of people's lives and also how long they live.

Health inequalities are unacceptable. They start early in life and persist not only into old age, but also into future generations of families. Some specific groups of people also experience much worse health than the rest of the population. Examples are people who are homeless, have mental health problems or those affected by long term unemployment.

It is not just where a person lives that determines their chances of a long life. It is also their access to income, employment, opportunities and life chances. The relationship between these issues, called *wider determinants of health* is complex. However, one very stark fact is that health inequalities are directly related to social class. This means the poorer a person is the shorter life they can expect to live.

3. Measures of health inequality

There are many ways to measure health inequality such as people's perception of their health and well-being or their absence from disease or illness. Life expectancy is generally used as a measure to compare health inequalities between different population groups or geographical areas. It is an estimate of the average number of years a new born baby would live if they experienced the age specific mortality[1] of the area in which they live. Life expectancy is one of the Government's national targets for reducing health inequalities.

Each district in the country is expected to meet a public service agreement (PSA) target for life expectancy which aims to:

> *Starting with local authorities, reduce by at least 10% the gap in life expectancy between the fifth of areas with the worst health and deprivation indicators and the population as a whole by 2010.*

Wirral falls into the 20% of local authority districts with the worst health and deprivation indicators (called spearhead authorities) and so will need to reduce by 10% the gap in life expectancy at birth by 2009-11[2] compared with the England average for the baseline year of 1995-97.

[1] Age related mortality is the remaining number of years a person of a specific age is expected to live
[2] Three year rolling data are used to ensure data robustness

4. Health inequalities in Wirral

4.1 Life expectancy

Table 1 shows the trend in life expectancy at birth for Wirral and England (1995/97–2005/07) and also the gap between the two.

Table 1: Life expectancy at birth in Wirral and England for 1995/97 to 2005/07

Time Period	England		Wirral		Gap (Years)		Gap (%)		Change in gap from baseline (%)	
	Males	Females	Males	Females	Males	Females	Males	Females	Males	Females
1995-1997	74.6	79.7	73.1	79.0	1.5	0.7	2.0%	0.9%	0.0%	0.0%
1996-1998	74.8	79.8	73.5	78.8	1.3	1.0	1.7%	1.3%	-14.0%	45.4%
1997-1999	75.1	80.0	73.8	79.1	1.3	0.9	1.7%	1.1%	-12.6%	33.1%
1998-2000	75.4	80.2	73.9	79.2	1.5	1.0	2.0%	1.2%	3.4%	38.6%
1999-2001	75.7	80.4	74.3	79.7	1.4	0.7	1.8%	0.9%	-7.2%	2.8%
2000-2002	76.0	80.7	74.9	79.9	1.1	0.8	1.4%	1.0%	-24.5%	9.5%
2001-2003	76.2	80.7	75.2	80.0	1.0	0.7	1.3%	0.9%	-34.6%	-2.5%
2002-2004	76.5	80.9	75.4	80.2	1.1	0.7	1.4%	0.9%	-26.3%	2.3%
2003-2005	76.9	81.1	75.5	80.2	1.4	0.9	1.8%	1.1%	-7.0%	19.6%
2004-2006	77.3	81.6	75.7	80.8	1.6	0.8	2.1%	1.0%	5.3%	12.9%
2005-2007	77.7	81.8	75.7	80.9	2.0	0.9	2.6%	1.1%	33%	28.6%

Key facts about achieving the life expectancy target in Wirral:

- Whilst life expectancy is increasing in Wirral, it is not improving at the same rate as England as a whole.
- The latest data (2005/07) shows a gap in life expectancy of 2.0 years for males and 0.9 years for females between Wirral and England.
- The gap has increased in both males and females since 1995/97 from 1.5 years for men and 0.7 years for females.
- Data up to 2001/03 show that Wirral was narrowing the gap for males (albeit inconsistently), however since then the gap has been widening year on year.
- Progress amongst females has been more erratic but, like males, the gap appears to be widening in recent years.
- According to this latest data, Wirral is not on track to meet the PSA life expectancy target along with many of the other Spearhead areas.

All age all cause mortality (AAACM[3]) is a measure used to monitor life expectancy. In Wirral, for 2005-2007 AAACM was 661.45 per 100,000 for males and 540.79 per 100,000 for females. The Wirral rate is lower than the North West as a whole (672.80) but higher than the England rate (594.73).

Health inequalities are also apparent within Wirral. Figures 1 and 2 show all age AAACM at Lower Super Output Area (LSOA[4]) across Wirral for females and males respectively.

[3] AAACM rates are three-year average, directly standardised death rates per 100,000 of the population for all ages and all causes of death

[4] LSOAs are areas with a mean population 1500, minimum population of 1000. There are 34,378 LSOAs in England and Wales and 207 in Wirral.

Figure 1: Female AAACM rates at LSOA (2005-2007)

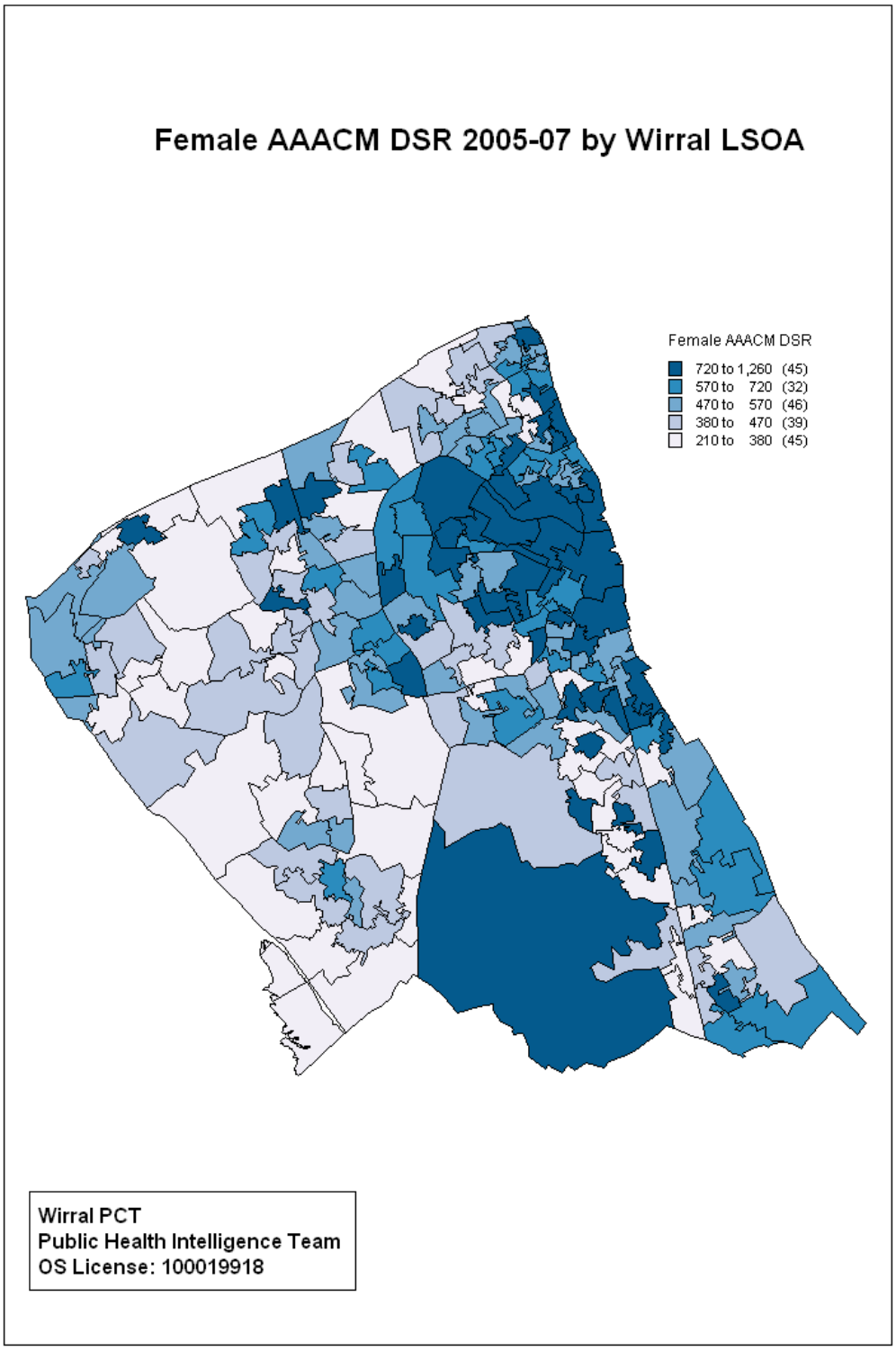
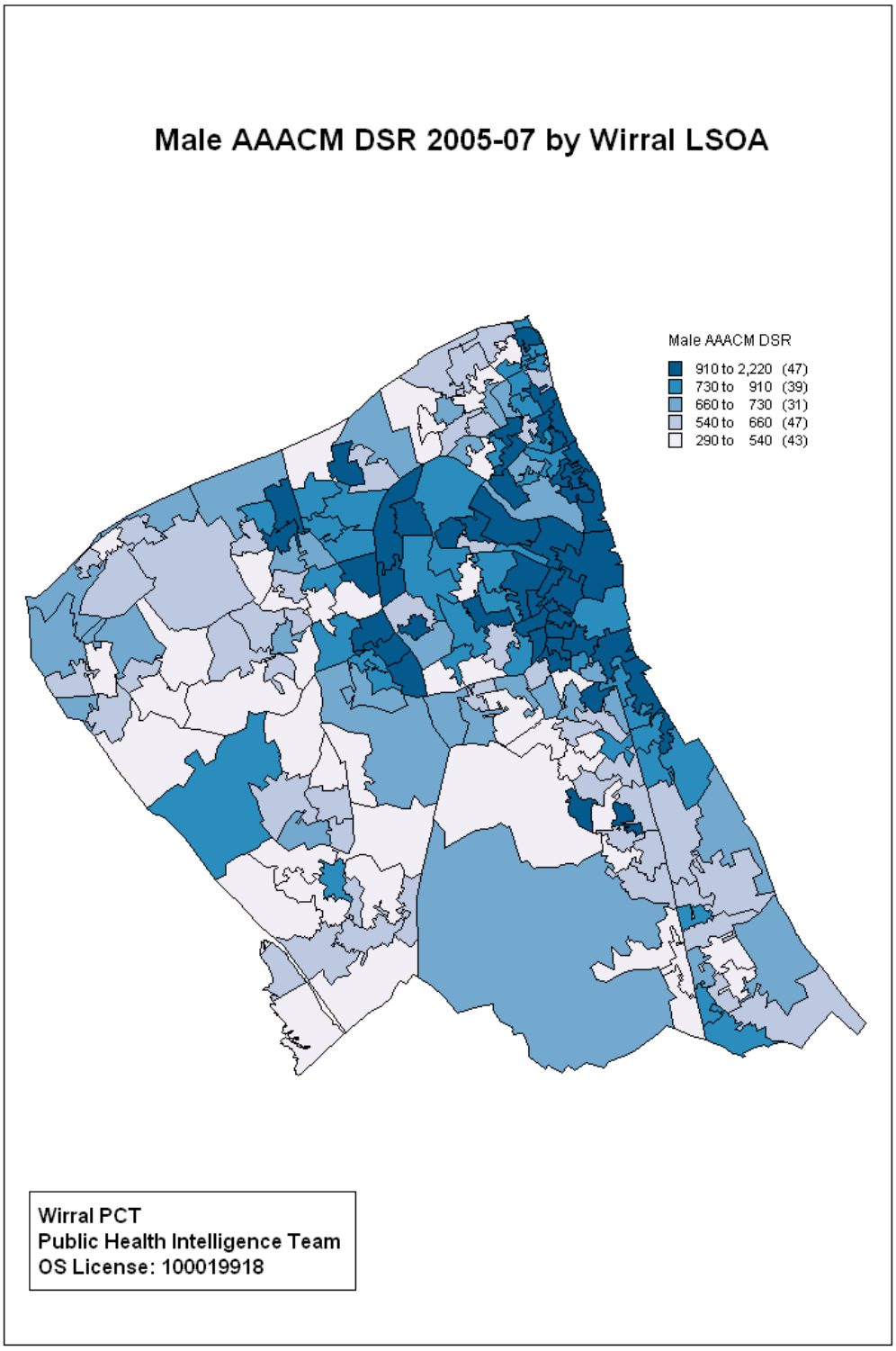


Figure 2: Male AAACM rates at LSOA (2005-2007)

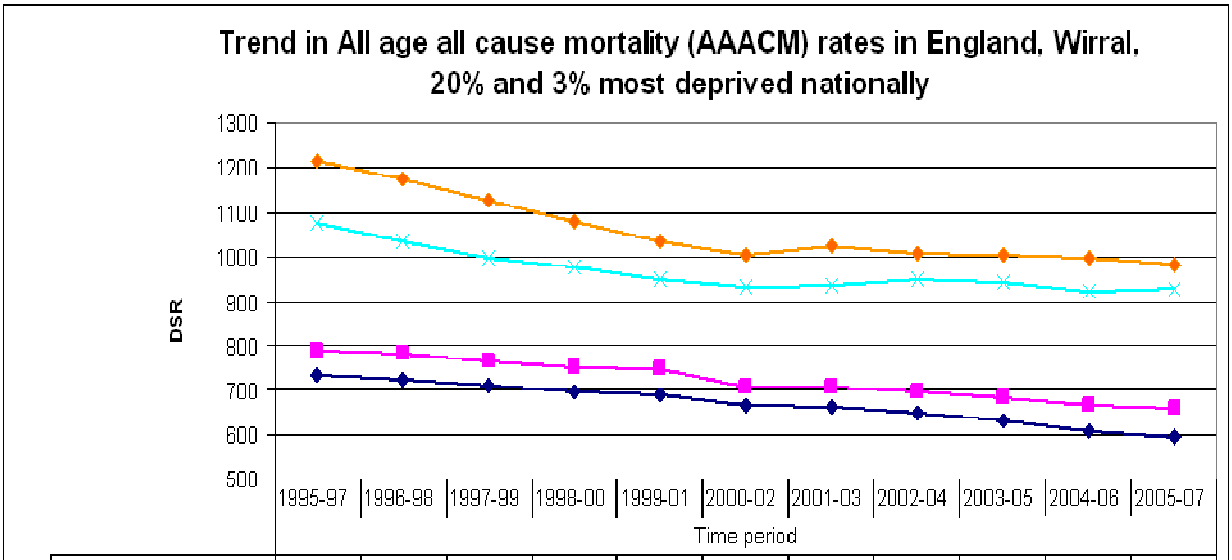


It is apparent from Figures 1 and 2 that mortality rates vary dramatically across Wirral LSOAs in both males and females. However, the variation in men is especially notable ranging from 290 to 2,220 deaths per 100,000 population. It is also clear that generally, the most disadvantaged areas in the east of Wirral have the highest death rates (and therefore lowest life

expectancy) whilst the most affluent areas have the lowest death rates (and therefore, highest life expectancy).

AAACM has been calculated in Wirral to demonstrate the differences in death rates between the whole of Wirral and areas that are expected to have poor life expectancy due to high deprivation. Figure 3 shows AAACM in England, Wirral overall, Wirral lower super output areas (LSOAs) which are in the 3% most deprived group nationally (which correspond to around 12% of Wirral's population) and the LSOAs which are in the 20% most deprived nationally (35% of Wirral's population).

Figure 3: AAACM in England, Wirral and 3% and 20% most deprived (1995/97 – 2005/07)



	1995-97	1996-98	1997-99	1998-00	1999-01	2000-02	2001-03	2002-04	2003-05	2004-06	2005-07
England	736	724	712	697	681	665	664	650	633	610	595
Wirral	791	782	765	754	748	708	709	696	685	666	661
3% most deprived	1214	1173	1126	1080	1034	1004	1026	1007	1004	988	984
20% most deprived	1075	1035	997	978	949	931	936	950	943	922	927

Key facts relating to AAACM:

- Wirral has a higher AAACM rate than England, and this has consistently been the case for the last ten years.
- Mortality rates are higher in the 3% most deprived group nationally and the LSOAs which are in the 20% most deprived nationally.
- Whilst overall mortality rates have improved in Wirral, in some of the most deprived areas (3% most deprived nationally) they have been increasing since 2002 although most recent data show a marked improvement (2005-2007).

4.2 Infant mortality and child deaths

Wirral has lower mortality rates amongst those aged under 1 year and under 28 days than the North West and England. However, the mortality rate amongst those aged under 7 days in Wirral in slightly higher than those for the

North West and England. It should be noted that none of these differences are statistically significant.

The most recently available infant mortality statistics are shown in Table 2 below.

Table 2: Infant mortality rates (2005/07)

	Rate per 1,000 live births		
	Under 1 year	**Under 28 days**	**Under 7 days**
Wirral	4.7	3.3	2.8
North West	5.5	3.6	2.7
England	4.9	3.4	2.6

When the causes of death for this period amongst this Wirral cohort (all deaths in those aged <1 year old between 2005 and 2007 inclusive) are examined, it becomes apparent that approximately one quarter of deaths relate to the length of gestation and fetal growth (i.e. premature babies) and an additional quarter are related to congenital and chromosomal abnormalities.

Additional analysis looking at the geographical spread of deaths finds no indication of an inequalities gap. However, it must be noted that the cohort is very small (n=55).

4.3 The main causes of early death

The main conditions for men and women that contribute to the gap in life expectancy between Wirral and England are shown in Table 3. The table also shows the number of deaths in Wirral from each condition.

Table 3: Main causes of early death in Wirral

Condition	Order of contribution to gap for women	Order of contribution to gap for men
Coronary heart disease	1=	1
Suicide and undetermined injury	7	2
Other accidents	13	5
Chronic cirrhosis of the liver	6	4
Lung cancer	3	3
Other cancers	1=	10
Stroke	5	9
COPD (Chronic obstructive airway disease)	4	6

Coronary heart disease is the greatest cause of the gap in life expectancy for both males and females, along with other cancers for females. Coronary heart disease (CHD), stroke and cancers contribute the greatest number of deaths. Risk factors that are common to these conditions include smoking, inactivity, high fat diet lacking in fresh fruit and vegetables, obesity and high alcohol consumption. These also contribute to raised cholesterol, blood pressure and

blood glucose which are major causes of cardiovascular disease including CHD, stroke and diabetes.

Suicide and undetermined injury is the second biggest contributor to the gap in life expectancy for Wirral in males. The main issue to address is alcohol binge drinking in men under 50 years and road traffic accidents in young men.

Deaths from causes considered amenable to healthcare is a definition based on the concept that deaths from certain causes could be avoided in the presence of timely and effective health care. This includes conditions such as many cancers, diabetes and measles. The mortality rate for these conditions is higher in Wirral than England with the differential particularly noticeable in men. It is well documented that men can be poor at accessing services and often present with late symptoms, affecting survival outcomes.

4.4 Self reported health and well-being

The North West Regional Lifestyle Survey took place in 2007. Individuals were asked several questions about their general health and long-term conditions. In Wirral, 79% of both males and females assessed their health as ‘very good’ or ‘good’ which was better than the Merseyside average from the Health Survey for England of 73% for males and females (3 year average for 2003-05). It is also better than the England average from the Health Survey for England of 76% for males and 75% for females.

Figures 4 and 5 show responses to health in general by gender and age for males and females. Both males and females show health deteriorating as they get older. A greater proportion of females than males in the older group (75+) rate their health as ‘very bad’. This fits in with other research that suggests that though women live longer, they often experience a longer period of time in poor health towards the end of their lives.

Figure 4: Self-reported health by Wirral males

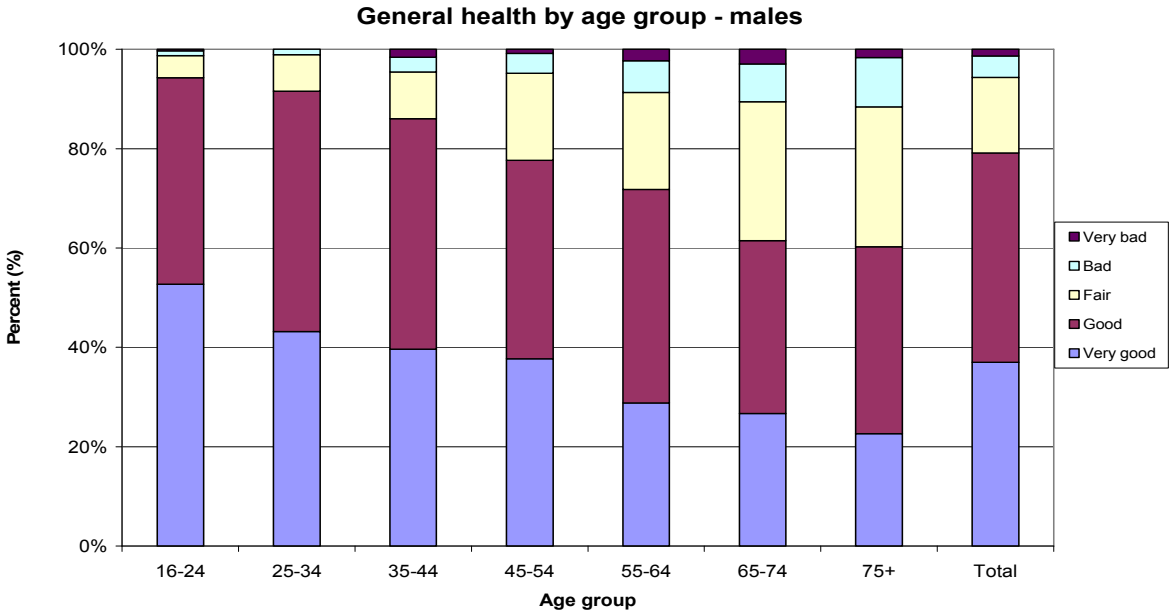


Figure 5: Self-reported health by Wirral females

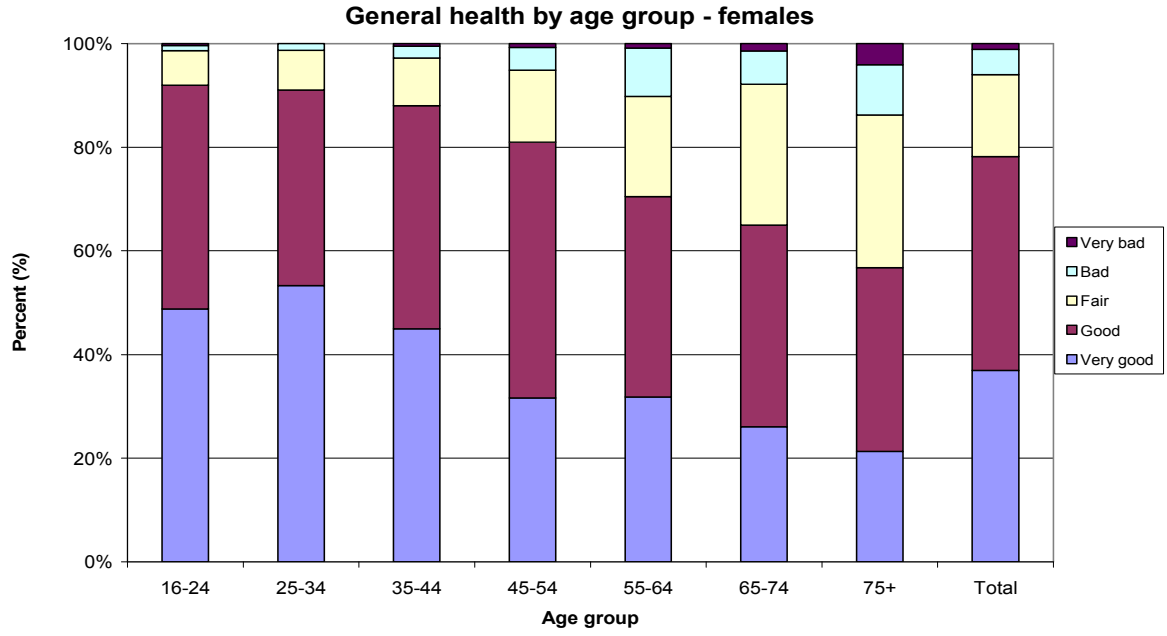
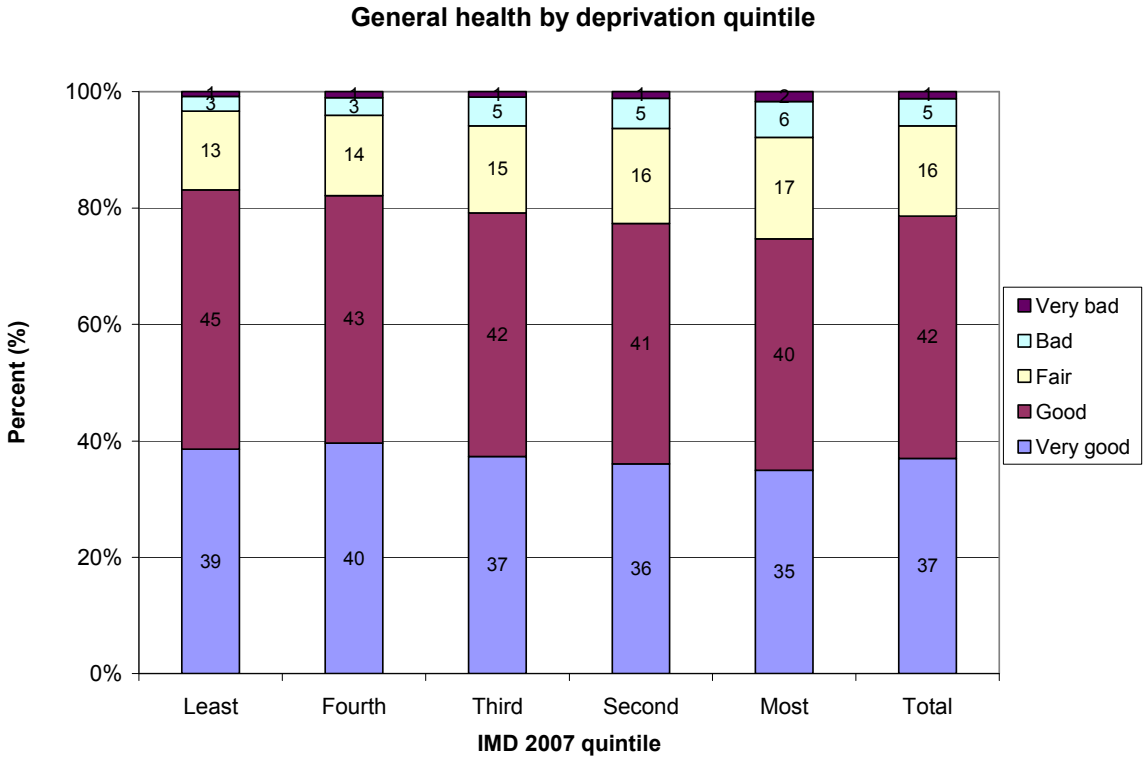


Figure 6 shows general health by deprivation quintile[5]. The percentage describing their health as 'bad' or 'very bad' is more than twice as high in the most deprived as in the least deprived; 7.8% compared with 3.3%.

[5] Deprivation quintile; the whole population is divided into fifths ranging from most to least deprived

Figure 6 – Self-reported health by deprivation quintile



The TellUs2 Questionnaire is a survey of children and young people in school years six, eight and ten across England covering a range of issues relating to the five Every Child Matters outcomes. The responses from Wirral and England pupils to the question "How healthy are you?" are shown in Table 4 below.

Table 4 – Responses to "How healthy are you?" from the TellUs2 survey (2007)

	Wirral (%)	**National (%)**
Very healthy	23*	31
Quite healthy	59	55
Not very healthy	12	9
Don't know	6	5

* Indicates significantly lower than the England response

It is clear from Table 4 that significantly fewer pupils in Wirral rate themselves as "very healthy" compared to England as a whole, whilst more rated themselves as "not very healthy".

Despite these findings, the Wirral Young People Survey (summer 2008) identified that overall Year 8 and Year 10 pupils feel responsible for their own health with 78% agreeing with the statement "If I take care of myself I'll stay healthy" and 71% agreeing with the statement "I am in charge of my health". Only 5% and 6% respectively disagreed with these statements.

4.5 Wirral's unique characteristics

Wirral is a borough of contrast and diversity in both its physical characteristics and social demographics. There are both rural areas and townships and

urban and industrialised areas in a compact peninsula of 60 square miles. Wirral is a peninsula, providing extensive opportunities for leisure through parks, open spaces and coast line.

Health and Local Authority agencies are co-terminus providing stability that has fostered mature partnership arrangements. The Strategic Partnership has shown its commitment to achieving reduced health inequalities through its Local Area Agreement (LAA). The LAA Wirral Story sets out the vision to achieve a more prosperous and equal Wirral, enabling all communities and people to achieve their full potential.

Wirral has a relatively high older population and a relatively low proportion of people in their twenties and thirties compared to England and Wales as a whole. The older population (aged 65 years and above) are expected to increase at the fastest rate (than any other age group) over the next two decades; between 2006 and 2031 it is estimated that this population group will have increased by 45%. According to estimates 4.5% of Wirral's population is from a BME group (i.e. not white British).

According to the Index of Multiple Deprivation (IMD) 2007, Wirral is the 60th most deprived of the 354 districts in the country and is in the bottom 20% nationally. Many of Wirral's citizens enjoy an excellent quality of life, with good quality housing, schools and living environment. In certain parts of the borough however, there are significant levels of deprivation. Within Wirral, LSOAs range from the 26th most deprived in the country (around St James Church in Birkenhead) to one of the least deprived in the country in South West Heswall, less than 6 miles away.

Wirral is ranked 8th worst out of 354 districts (bottom 3% nationally) for employment in the IMD 2007. There are huge variations in levels of economic inactivity across the borough, from over 56% in some areas of Birkenhead and Tranmere, to less than 3% in parts of Heswall. Although average wages paid in Wirral are lower than for the North West, the average wage earned by Wirral residents is higher. This is due to the fact that more than 40,000 residents currently travel outside Wirral to access higher paid employment in Liverpool and Chester.

Wirral's senior school system includes six selective non fee-paying senior schools, which have higher academic attainment than the state schools. Although the schools are non fee-paying there are inequities in attendance at these schools with respect to the areas from which pupils are resident. 6.8% of pupils from the most disadvantaged wards[6] attend one of these schools (ranging from 3.2% of pupils from Seacombe to 10.4% of pupils from Leasowe) whilst 32.4% of pupils from the other wards attend one of these schools.

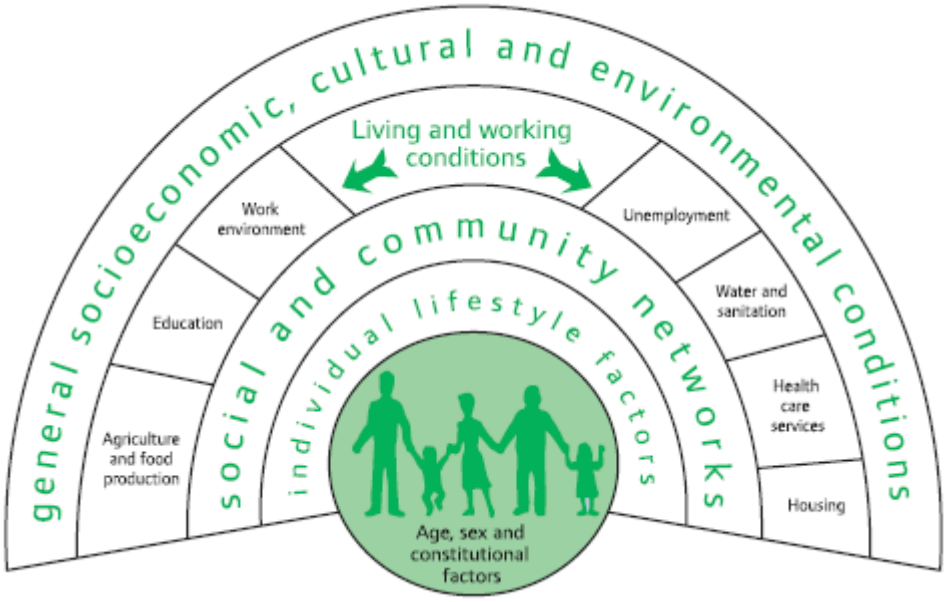
[6] Bidston, Birkenhead, Leasowe, Seacombe, Tranmere

4.6 Wider determinants of health

An effective strategy to reduce health inequalities in Wirral will need to address factors at the individual, family, community and population level. This means not only tackling the conditions leading to reduced life expectancy, (such as CHD and smoking) but addressing the underlying social inequalities that influence how people live (such as poverty, education and employment).

In addition, social networks and quality of life can have an influence on mental well-being, self esteem and resilience. These are protective factors against health damaging behaviour such as smoking or alcohol abuse. They also influence employability for example, where worklessness is associated with poor mental health and well-being. These underlying issues are often referred to as wider determinants of health and their inter-relationship is demonstrated in Figure 7.

Figure 7: The Determinants of Health



Source: Dahlgren G and Whitehead M, *Policies and strategies to promote social equity in health,* Stockholm: Institute of Future Studies, 1991.

As previously discussed in Section 4.5, Wirral is 60th worst out of 354 districts in IMD 2007. This is an improvement on IMD 2004 when Wirral ranked 48th worst. Wirral's area of poorest performance on IMD is in the employment domain, where it ranks 8th worst out of 354 districts, the same as in IMD 2004. Given that employment makes up 22.5% of the total IMD score, this is the key contributor to Wirral's overall low ranking.

Wider determinants of health such as working conditions, the environment or crime, lie outside the control of individuals and require societal changes or policy decisions eg legislation to introduce smoke free work places. However, addressing the wider determinants can enable people to make healthy

personal choices to improve or maintain their health. To be effective, it is important that consideration is given to what can be achieved at a local neighbourhood level, what would be more effectively tackled at a district or regional level and what can only be achieved with national and international policy legislation change.

5. Vision for Wirral

In order to achieve a reduction in health inequalities, it is necessary to define targets and outcomes and how they will be measured. Three timescales for achievement of outcomes have been agreed that are short, medium and longer term:

- December 2011 - Three year rolling averages are used to measure life expectancy. To achieve the 2010 PSA target of a reduction in life expectancy gap of 10% between Wirral and England, Wirral must make ambitious plans to reduce premature mortality in each of the years 2009 to 2011. Wirral's Local Area Agreement will contribute to achieving this target
- 2013 – NHS Wirral Strategic Plan sets out targets that will contribute to reduced health inequalities by 2013
- 2025 – The Children and Young Peoples Plan, Employment and Investment Strategies and Sustainable Communities Strategy set out targets to improve wider determinants of health, contributing to reduced health inequalities by 2025.

The Action Plan (appendix 1), will prioritise actions required to meet agreed improvements at each of the three timescales above.

5.1 Overarching health outcomes

This Health Inequalities Action Plan aims to achieve the following health outcomes:

Health outcome 1:
Health in Wirral will improve at a faster rate than for England as a whole between 2009 and 2011. This will ensure that the 2010 life expectancy target for Wirral is achieved.
Measures to be set and achieved:

- The AAACM trajectory for males and females.
- Total number of deaths to be saved each year in order to meet the AAACM trajectory
- Number of deaths to be saved each year from the main contributors to the gap in life expectancy:
    - Cardio vascular disease and stroke
    - Excess winter deaths
    - COPD
    - Cancers
- Number of deaths under the age of 50 years to be saved each year due to suicide and undetermined injury.

Health outcome 2:
The health of people living in the most deprived areas of Wirral will improve at a faster rate than for the rest of Wirral between 2009 and 2013
Measures to be set and achieved:

- The AAACM trajectory for males and females living in the national 20% most deprived areas of Wirral in order to achieve a 7% reduction in the gap in life expectancy within Wirral between 2008 and 2013.

Health outcome 3:
Wirral will improve its index of multiple deprivation position in comparison to other Local Authority Districts by 2020

- Improvement to child poverty leading to fewer children living in poverty
- Improvement to employment rate leading to more people being in work
- Improved educational attainment for vulnerable children including looked after children and children from the most deprived areas

It will be necessary to model the possible impact of the economic downturn over the lifetime of this plan. This will help to ensure that achievement of outcomes and performance measures show the real improvement that has been achieved against performance projected if the plan were not implemented.

5.2 Strategic priorities

Actions to meet the Overarching Health Outcomes have been grouped under five Strategic Priorities:

- ***Strategic Priority 1***: Address the underlying determinants of health
- ***Strategic priority 2***: Improve access to high quality public services for people with poor health and well-being
- ***Strategic Priority 3***: Engage communities and individuals, supporting them to improve their health through the health and well-being choices they make
- ***Strategic Priority 4***: Improve opportunities for children, young people and families
- ***Strategic priority 5***: Improve and share data and intelligence on health and well-being

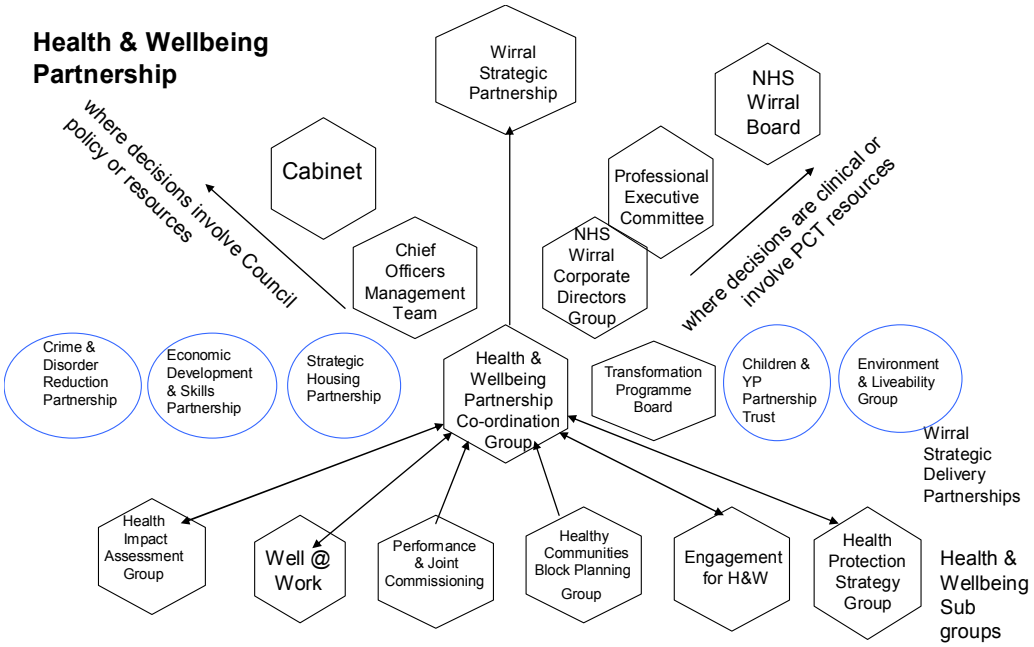
The actions are detailed in the Health Inequalities Plan – Action Plan (Appendix 1).

6. Strategic leadership and governance arrangements (*to be revised)*

The Health and Well-being Partnership Co-ordination Group will provide leadership and governance for the implementation of the Health Inequalities Action Plan, through its network of strategy groups and clinical networks (Figure 8). This will report quarterly to the Wirral Strategic Partnership Executive.

A Health Inequalities Lead Group will be established to drive forward the accountability, implementation, performance monitoring and reporting on the plan. This group will also ensure that there is regular reporting to appropriate boards / cabinet.

Figure 8. Health and Well-being partnership



7. Communication

The Health and Well-being Partnership communicates in a number of ways including the cross membership of officers & executives on various boards and other strategic groups.

The Partnership is accountable to the Wirral Strategic Partnership Executive. However where decisions involve Council policy or resources it is also accountable to the Council's Cabinet and/or where decisions are clinical or involve NHS Policy or resources it is also accountable to the NHS Wirral Board via the Professional Executive Committee (PEC). The Joint Director of Public Health will also take advice from the Chief Officers Management Team (COMT) and/or the Corporate Directors Group (CDG) on the process required for specific decisions.

It is intended that members of the various groups within the structure will be kept informed and engaged through regular newsletters, training and development opportunities in order to enable them to champion health and wellbeing and health inequalities issues within their wider work. This

represents a further development within Wirral of the successful Cheshire and Merseyside Public Health Network for Health (ChaMPs).

Appendix 1
Health Inequalities Plan – Action Plan

Strategic priority 1: Address the underlying determinants of health

Target	Action	Outcome	Lead person and organisation	Achieved by:	Relevant delivery strategy	Impact to be achieved by		
						2011	2013	2025
1.1 Ensure that development plans for Wirral Waters maximise positive impact on health inequalities	Complete a health impact assessment on Wirral Waters Development Plan including recommendations for action	Wirral Waters development reduces health inequalities in Wirral	WMBC Head of Housing and Regeneration Joint Head of Health and Well-being	January 2010	Wirral Investment Strategy		√	√
1.2 Set in place an effective strategy for reducing the availability of illegal, poor quality and reduced cost tobacco products, especially to young people and disadvantaged adults	Review and re launch the Smoke Free Wirral Action Plan	Measures to reduce smoking prevalence are not undermined by local illegal practice	WMBC Head of Regulation / Joint Head of Health and Well-being /	June 2009	Health and Well-being Strategic Framework		√	√

1.3 Ensure that vulnerable individuals are able to live in homes that are warm	Review the Affordable Warmth Strategy and ensure there is an effective partnership group to lead an associated action plan Increase the number of vulnerable households assisted with at least one main energy efficiency measure under Warm front (LAA – local target)	Vulnerable families and individuals can afford to live in homes that protect rather than negatively impact on their health	WMBC Head of Housing Head of Health and Well-being (DASS) Director of Strategic Partnerships Head of Inclusion	September 2009	Affordable Warmth Strategy Housing Strategy DASS Transformation Strategy Warm Front LAA	√	√	√
1.4 Ensure key agencies and Wirral Strategic partnership have sufficient information to lead action to address excess winter deaths	Set in place the mechanism to collate and report on excess winter deaths including number and locality	High level of support is maintained to reduce excess seasonal deaths	WUTH Head of PCIS / Head of Performance and Intelligence / Asst Director of Strategy	September 2009	Older People's Plan Health Protection Strategy	√	√	√
1.5 Improve data collection and intelligence on black and racial minority	Carry out a health and well-being needs assessment amongst the BRM population	Some of the barriers for BRM groups accessing services are	NHS Wirral Joint Head of health and Well-being / Wirral	December 2009	Joint Strategic Needs Assessment			√

populations in Wirral	Establish fit for purpose data collection methods within key services to assess access by BRM groups	removed	Change / WMO Head of Performance and Intelligence / Head of PCIS / Head of Provider Services	March 2010				
1.6 Reduce economic inactivity	Reduce the proportion of working age people claiming out of work benefits (LAA / NI153) Reduce the number of people claiming incapacity benefits	Reduced impact of poverty on families and reduced loss of self esteem and mental well-being	WMBC Head of Housing and Regeneration / Head of Public Health Provider Services / Benefits Agency	March 2010 / 2011	Local Area Agreement Wirral Investment Strategy			√
1.7 Support the development and maintenance of skills and independence in vulnerable adults	Increase the number of people supported to live independently through social services - all adults (LAA local target)	Increased quality of life, health and well-being in vulnerable adults	WMBC Director of Adult Social Services / Director of Strategic Partnerships	March 2010 / 2011	Local area Agreement		√	√
1.8 Maximise	Steps are in place to	Impact on	WMBC	March				√

the health and well-being impact of new programmes and policy changes on potential vulnerable and excluded groups	carry out equality and diversity impact assessment on all new programmes and policies	potentially vulnerable or minority groups is considered at the planning stages and positive impacts maximised and negative impacts reduced	Directors of HR in partner organisations	2010				

Strategic Priority 2: Improve access to high quality public services for people with poor health and well-being

Target	Action	Outcome	Lead person and organisation	Achieved by	Relevant delivery strategy / plan	Impact to be achieved by		
						2011	2013	2025
2.1 Improved QOF performance in areas that are major contributors to reduced mortality	Review practice QOF scores in all high impact areas and identify low scoring practices (eg CHD 5,6,7,9) Support low scoring practices to produce a recovery plan to achieve maximum QOF points in high impact areas	Increase in the proportion of patients identified and treated leading to reduced risk of premature mortality	NHS Wirral Head of Performance and Intelligence / Heads of Localities	June 2009 September 2009	LHD plans / PBC plans	√	√	√
2.2 Use financial incentives and local payment schemes to maximise impact on life expectancy and health inequalities	Review PCT and LHD local enhanced services against performance, heath impact and value for money Review exception policy for practices and impact on health inequalities Review the support, resources and	PCT resources are targeted to achieve reduced health inequalities	NHS Wirral Director of Health Systems Management Medical Directors / Director of Health Systems management /	June 2009 June 2009 July 2009	Strategic Plan / LHD Plans	√	√	√

	development available to practices to reduce exception reporting, achieve higher QOF and LES activity in high impact areas		Joint Director of Public Health					
2.3 Ensure quality training is available to practice staff and that records demonstrate high levels of completion	Review the training needs of practice staff to achieve performance improvements in the health inequalities high impact areas Establish systems to maintain and review up to date training records of primary care staff Agree standards for training and development linked to quality payment scheme	Staff development is supported at LHD level to ensure consistently high standards of care	NHS Wirral Medical Directors / Head of Localities	January 2010			√	√
2.4 Identify inequalities in the prevention, diagnosis and treatment of cancer and CVD	Complete a cancer equity audit review and produce an improvement action plan to implement recommendations	Inequalities in cancer and CVD morbidity and mortality are reduced	NHS Wirral Public Health Consultant / Performance and Intelligence team / PCT	December 2009	Cancer Equity Audit CHD Equity audit	√	√	√

	Complete a CVD equity audit review and produce an improvement action plan to implement recommendations		Cancer Lead / PCT CVD lead					
2.5 Ensure patients with high risk of CVD and not in contact with primary care are supported to maximise their risk reduction	Establish interface between Health Action Areas and Primary Care to ensure data and patients are supported to move between clinical and lifestyle programmes	CVD risk is reduced within the population leading to reduced mortality	NHS Wirral Medical Director lead for CVD / Joint Head of Health and Well-being / LHD Analyst / Head of Public Health Provider Services	June 2009	Vascular Screening Delivery Plan HAA Delivery Plan	√	√	√
2.6 Ensure that structural constraints are removed if they prevent services from collaborating to deliver improved health and wellbeing to the population	Review the partner alignment and structures for delivering services to children, young people and adults and make recommendations for maximising resources, quality and equity of access	Organisational boundaries are aligned leading to integrated health and social care services	NHS Wirral Director of ASS, Director of CYPD, Director of Strategic Partnerships / Director of Primary Care	September 2010	Children and Young Peoples Plan Joint Commissioning Plans		√	√
2.7 Patients treated for angina	Protocols for the referral of patients with angina	Patients with angina are	NHS Wirral Head of Heart	September 2009	CVD Delivery Plan??	√	√	√

are supported to adhere to their care plan	for exercise tolerance testing are reviewed and procedures set in place to ensure minimum standards are achieved and adherence to care plans reviewed	able to manage their condition to reduce risk of premature mortality	Centres/ Medical Director lead for CVD/ PCT commissioning lead for CVD					
2.8 Increase support available for patients with CVD to adhere to medication therapy	Review the support available for patients on medication to reduce CVD risk and make recommendations for improving	Patients adhere to medication regimes, reducing risk of premature mortality	NHS Wirral Head of Medicines Management / Head of Heart Centres / Medical Director lead for CVD / Head of Engagement	September 2009		√	√	√
2.9 Increase revascularisation rates	Benchmark revascularisation rates and set out mechanisms to ensure PCT is in top 10% nationally (whilst reducing any inequity of access)	Patients are provided with optimum acute treatment to reduce premature mortality	NHS Wirral Head of Performance and Intelligence / Commissioning lead for CVD	September 2009		√	√	√
2.10 A care pathway is in place and being adhered to for	Consult with relevant clinical and patient groups to agree and launch a map of	Patients are treated and have optimum quality of life	NHS Wirral Consultant in Cardiology/ PCT CVD lead	January 2010		√	√	√

primary angioplasty	medicine care pathway for primary angioplasty		/ Medical Director lead / Director of Health Systems management					
2.11 Retention and completion within cardiac rehabilitation programmes is maximised	Complete a review of attendance, retention and completion of cardiac rehabilitation programmes, including equity of access from people from most deprived areas and high risk population groups Set in place an action plan to improve adherence and increase equity of access	Patients most at risk of premature mortality from CVD are completing cardiac rehabilitation programmes	NHS Wirral Head of Heart Centres / Head of Performance and Intelligence	November 2009 January 2010		√	√	√
2.12 Prescribing recommendations relating to Champix are changed to ensure it is made available as a first line intervention	Current prescribing guidance is reviewed to upgrade Champix as a first line intervention in line with guidance	Smokers wishing to quit have access to the most effective pharmaceutical products available	NHS Wirral Head of Medicines Management / Head of Public Health Provider Services	June 2009	Smoke Free Wirral Health and Well-being Framework		√	√
2.13 Improve stop	Review support	Increase in the	NHS Wirral	April 2009	Smoke Free		√	√

smoking success rates from 35% to 50%	available to intermediate stop smoking services and set in place action to improve follow up and ongoing engagement of smokers to improve success rates	number of people stopping smoking	Head of Public Health Provider Services / Head of Medicines Management / Heads of Localities	– March 2010	Wirral Health and Well-being Framework			
2.14 Ensure that smokers with high risk co-morbidities are targeted to stop smoking	Produce action plan to target high risk smokers with support to quit	High risk smokers helped to reduce overall risk of premature mortality	NHS Wirral Medical Directorate Manager (WUTH) / Head of Heart Centres / Joint Head of Health and Well-being / Head of Public health Provider Services	June 2009	Smoke Free Wirral Health and Well-being Framework	√	√	√
2.15 Produce an action plan to address excess cancer deaths in Wirral	Conduct a review into excess cancer deaths, particularly for women Produce a resourced action plan to reduce cancer excess deaths at	Death rate from cancer is reduced	NHS Wirral Clinical Cancer Lead / Public Health Consultant / Head of Performance	September 209 January 2010		√	√	√

	least in line with statistical neighbours		and Intelligence					
2.16 Services for breast cancer are reviewed and recommendations implemented	Commission a review of breast cancer services and make recommendations for areas of improvement	Breast cancer services from screening through to diagnosis, treatment and end of life care provide optimum care and health outcomes	NHS Wirral Cancer Commissioning lead / Public Health Consultant / Clinical Cancer Lead / Medical Director lead for Cancer	December 2009			√	√
2.17 Identify, support and reduce the risk of excess winter death amongst vulnerable older people	Work in partnership to identify people most at risk from seasonal winter death / hospital admission (winter risk list) Ensure there is a care worker in place with agreed care protocols for regularly reviewing the care of those people on the winter risk list Establish a Winter Planning Group to	Excess winter deaths are reduced	NHS Wirral Director of Strategic Partnerships / Director of Adult Social Services / Medical Directorate Manager (WUTH) / Director of Primary Care / Head of Housing	July 2009 September 2009 July2009	Older People's Plan Organisational and partnership escalation plans Health Protection Strategy Affordable Warmth Strategy	√	√	√

	ensure that partnership plans are in place to manage increased health risk associated with the winter season							
2.18 Establish care pathways for alcohol	Review, revise and promote care pathways for alcohol	Care pathways are clearly articulated enabling people to be provided with the appropriate access and care in relation to their drinking	NHS Wirral Alcohol Programme Manager / Medical Director lead	June 2009	Alcohol Harm Reduction Strategy	√	√	√
2.19 Review implementation of care pathway	Identify points in the care pathway for alcohol that have high rates of disengagement and review systems to improve adherence and outcomes (including engagement from hard to reach group such as those in criminal justice system)	Alcohol pathway supports people to change their behaviour and achieve improved health	NHS Wirral Alcohol Programme Manager	March 2010	Alcohol Harm Reduction Strategy		√	√
2.10 Review alcohol interventions to	Review all existing and planned alcohol interventions and	Maximum reductions in alcohol related	NHS Wirral Alcohol Programme	September 2009			√	√

ensure health outcomes from invested resources are maximised	services ensuring there is systematic evaluation of outputs, outcomes and value for money	harm are achieved through the alcohol programme investments	Manager / Head of Research and development / Performance and Intelligence Team					
2.21 Ensure children and young people at risk of repeat self harm or alcohol misuse are provided with effective information on alcohol	Review protocols for providing information to children and young people following self harm to ensure it routinely includes alcohol brief intervention	Children and young people are supported to reduce their risk of repeat self harm	NHS Wirral Alcohol Programme Manager	January 2010	Alcohol Harm Reduction Strategy			√
2.22 Identify people on GP registers at risk of chronic ill health due to alcohol	Develop a mechanism to identify patients on GP registers that are at risk of chronic ill health due to alcohol Implement a mechanism to search, review and sign post to alcohol pathway and follow up, patients at	Patients at risk of chronic ill health are provided with appropriate intervention and support to improve quality of life and reduce premature	NHS Wirral Alcohol Programme Manager / Head of Performance and Intelligence / Medical Director Lead	September 2009 April 2010	Alcohol Harm Reduction Strategy		√	√

	risk	mortality						
2.23 Ensure that obese people with co-morbidities are provided with interventions that improve their quality of life and reduce premature mortality	Establish comprehensive care pathways for primary and secondary prevention and treatment of obesity	Obese patients are treated in order to maximise their health gain	NHS Wirral Joint Head of Health and Well-being / Medical Director lead for obesity	April 2009	Health and Well-being Framework		√	√

Strategic priority 3: Engage communities and individuals, supporting them to improve their health through the health and well-being choices they make

Target	Action	Outcome	Lead person and organisation	Achieved by	Relevant delivery strategy	Impact to be achieved by		
						2011	2013	2025
3.1 Reduce smoking prevalence by 8,000 smokers per year	Develop and implement an action plan to target manual workers and high prevalence communities to achieve an additional 5,000 people stopping smoking each year	The programme will contribute 5,000 people stopping smoking to an overall target of 8,000 fewer smokers per year	NHS Wirral Joint Head of Health and Well-being / Head of Public health provider services / Director of Communications	March 2010 / 2011 / 2012 / 2013	Smoke Free Wirral	√	√	√
3.2 Work to a shared vision for partnership, third sector and public	Agree and complete an engagement process with the voluntary sector to identify key actions and programmes that	Programmes and initiatives being delivered by the voluntary	MBW Head of Engagement / VCAW / Community	July 2009			√	√

engagement	will impact on health inequalities and the outcomes they will achieve against each of the target timescales Develop a partnership engagement strategy for the Wirral Strategic Partnership	sector will be fully resourced and evaluated against the health inequalities targets	Engagement Manager					
3.3 Identify people not in contact with primary care services and support them to reduce health and well-being risk	Screen 4,000 people per year for vascular risk, targeting people least likely to be in contact with primary care (eg manual workers, men aged 40-75, substance misusers, offenders and homeless) Deliver a community programme of activities that support people at high risk of premature mortality to change behaviour through increased physical activity, reducing smoking, reducing	Vascular screening programme will reach people most at risk of premature mortality and not in contact with primary care Individuals will be supported to achieve risk reduction leading to reduced	NHS Wirral Joint Head of Health and Well-being Head of Public Health Provider Services	April 2009 to March 2011	CVD Prevention Plan	√	√	√

	alcohol consumption, improved diet and improved mental well-being Ensure the Health Trainer workforce are linked to practices to support patients at high risk to make lifestyle changes	population risk of CVD						
3.4 Front line staff confidently raise the issue of lifestyle behaviours and provide confident brief interventions and sign posting	A minimum of 500 front line staff are trained each year	Every contact with a health and social care professional promotes and supports healthy lifestyle behaviours	NHS Wirral Joint Head of Health and Well-being / Head of Public Health Provider Services / Heads of Services in NHS and partner organisations	Annually from April 2010	CVD, Cancer and Diabetes Health Improvement Plan Alcohol Risk reduction Strategy Mental Health Promotion Strategy	√	√	√
3.5 Develop and implement a plan for increasing health gain in	Develop and implement a Health Action Area Plan to accelerate health improvement in the 3% and 20% most	Health improves at a faster rate in the 3% and 20% areas of	NHS Wirral Joint Head of Health and Well-being / Head of Public Health	May 2009	Neighbourhood management Plans Health and	√	√	

the most deprived areas of Wirral	deprived areas of Wirral	Wirral than for the whole of Wirral in 2009, 2010 and 2011	Provider Services / Neighbourhood Managers		Well-being Strategy LAA Sustainable Communities Strategy			
3.6 A strategic approach to social marketing is developed	Review resources and programmes currently invested in promoting health and well-being to tackle health inequalities Produce a fully resourced health and well-being priority communications plan including social marketing programmes – to cover as a minimum alcohol harm reduction, smoking, recognising early signs and symptoms of stroke and CVD	Public awareness of health and well-being messages is improved and people are motivated to make behaviour changes	WMBC Head of Communications (MBW) / Director of Communications (NHS Wirral) / Joint Head of Health and Well-being / Alcohol Strategy Manager / CVD Lead / Head of Public Health Provider Services	June 2009 August 2009	Health and Well-being Strategic Framework		√	√
3.7 Increase opportunities to	Provide affordable warmth information	Older people have	NHS Wirral Head of Health	September 2009 to	Affordable Warmth		√	√

provide information about affordable warmth for vulnerable adults	alongside flu campaign	increased access to information about affordable warmth	Protection / Heads of LHDs / Joint Head of Health and Well-being / Head of Housing and Regeneration	February 2010	Strategy Health Protection Strategy			

Strategic Priority 4: Improve opportunities for children, young people and families

Target	Action	Outcome	Lead person and organisation	Achieved by	Relevant delivery strategy / plan	Impact to be achieved by		
						2011	2013	2025
4.1 Reduce under 18 conceptions by 50% (LAA NI 112)	Implement the Teenage Pregnancy Priority Action Plan	Reduce the number of children in poverty / improved life chances for children	NHS Wirral Joint Director of Public Health / Head of Branch Children's Social Care	December 2010	Local Area Agreement NHS Wirral Strategic Plan	√	√	√
4.2 Reduce the number of children seriously injured or killed due to accidents	Reduce the number of children seriously injured or killed in road traffic accidents (LAA NI 48) Review and revise child accident prevention programmes	Improved quality of life and life expectancy	WMBC Group Leader Road Safety Services / Joint Head of Health and Well-being	March 2010 / 2011 March 2010	Local Area Agreement Wirral Road Safety Plan Being healthy Plan	√	√	√

4.3 Reduce the proportion of the population that are obese, starting with children and families	Reduce the proportion of children aged 4-5 (LAA NI 55) years and 10-11 years that are overweight and obese Review and implement the Child Obesity Priority Action Plan Review and revise care pathways for preventing and treating child obesity Increase breast feeding rates with a focus on most deprived areas	Reduced child and family overweight and obesity leading to improved health, self esteem, mental well-being and outcomes for children	NHS Wirral Joint Head of Health and Well-being / Head of PCT Provider Services / Head of School Nursing / Head of Midwifery	March 2010 / 2011 September 2009 May 2009	Health and Well-being Strategic Framework NHS Wirral Strategic Plan Cheshire and Merseyside Healthy Weight Framework			√
4.4 Protect children from the harmful effects of tobacco	Set and achieve a target to reduce the proportion of women who continue to smoke throughout pregnancy Implement a campaign to reduce childhood exposure to second hand smoke, including the training of front line staff	Reduced infant mortality Reduced childhood respiratory illness	NHS Wirral Head of Public Health provider Services / Performance and Intelligence Team / Joint Head of Health and Well-being	September 2009 March 2010	Health and Well-being Strategic Framework			√

4.5 Enable young people to access high quality education, training and employment that provides them with positive life choices	Reduce the proportion of 16-18 year olds that are not in education, employment or training (LAA NI 117) Set in place policies in the LAA partnership agencies to support the training and access to local jobs for Wirral young people	Young people have improved life chances Reduced economic inactivity and associated poverty	WMBC Connexions / Director of CYPD / Directors of HR for NHS / Local Authority	March 2010 / 2011 March 2010				√

Strategic Priority 5: Improve and share data and intelligence on health and well-being

Target	Action	Outcome	Lead person and organisation	Achieved by	Relevant delivery strategy	Impact to be achieved by		
						2011	2013	2025
5.1 Develop shared ownership of progress towards achieving health inequalities targets	Identify key health inequalities metrics and develop reporting (eg. MIS)	Leads for delivering the health inequalities action plan are able to assess progress and adjust plans	WMBC Head of Corporate Performance / Head of Performance and Intelligence / Joint Head of Health and	July 2009	Sustainable Communities Strategy Joint Strategic Needs Assessment	√	√	√

			Well-being /					
5.2 Increase use of shared data and intelligence	Develop and implement a Shared Data and Intelligence Plan for health and well-being	Commissioning plans are based on up to date intelligence, maximising impact on health inequalities	NHS Wirral Directors of Public Health / Adult Social Services / Children and Young People's Department	December 2009	Sustainable Communities Strategy Joint Strategic Needs Assessment Health and Well-being Strategic framework		√	√
5.3 Neighbourhood Action Plans identify gaps and opportunities to improve health and well-being	Health and well-being data and intelligence available to neighbourhood management programmes in the 20% most deprived areas are reviewed and made available to compliment local intelligence	Neighbourhood Development Programmes are supported to achieve reductions in health inequalities	NHS Wirral Joint Head of health and Well-being / Head of Performance and Intelligence / Neighbourhood Managers Head of Strategic Development and Investment	September 2009	Neighbourhood plans		√	√