



Wirral Neighbourhoods Care Model

How we will address Health Inequalities

Proposed Model and Approach

Why do we need to change?



Historic approach to health inequalities has not delivered

Inequalities and unexplained variances in health outcomes continue

Impact of pandemic and cost of living crisis increasing health inequalities

Levels of deprivation increasing

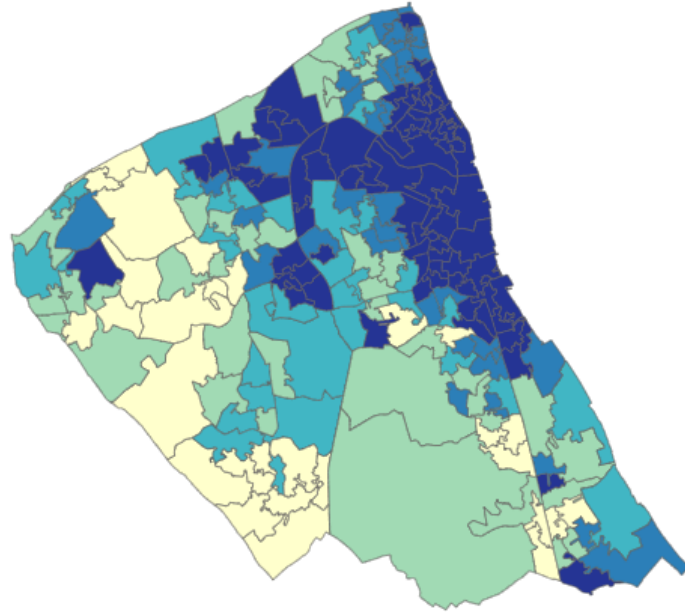
Joint working in pandemic has shown real benefits

Neighbourhood and PCN footprints not changing

INDICES OF DEPRIVATION

IMD 2019 by Deprivation Quintile and LSOA

Deprivation Qu... ● 1 (Most Deprived) ● 2 ● 3 ● 4 ● 5 (Least Deprived)



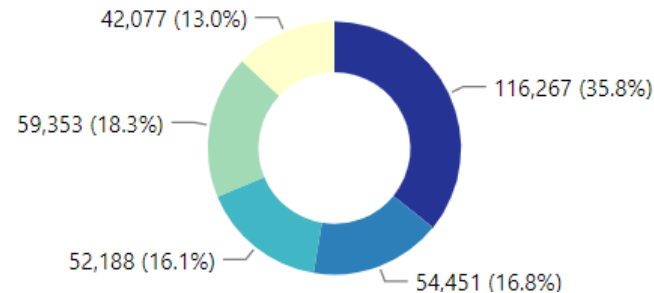
Most Deprived Summary

In total **72** out of **206** LSOAs are in the most deprived 20% national quintile, this means that for the **total population** there are **116,267** out of **324,336** (**35.8%**) people living in the 20% most deprived areas of England.

Least Deprived Summary

In total **28** out of **206** LSOAs are in the least deprived 20% national quintile, this means that for the **total population** there are **42,077** out of **324,336** (**13.0%**) people living in the 20% least deprived areas of England.

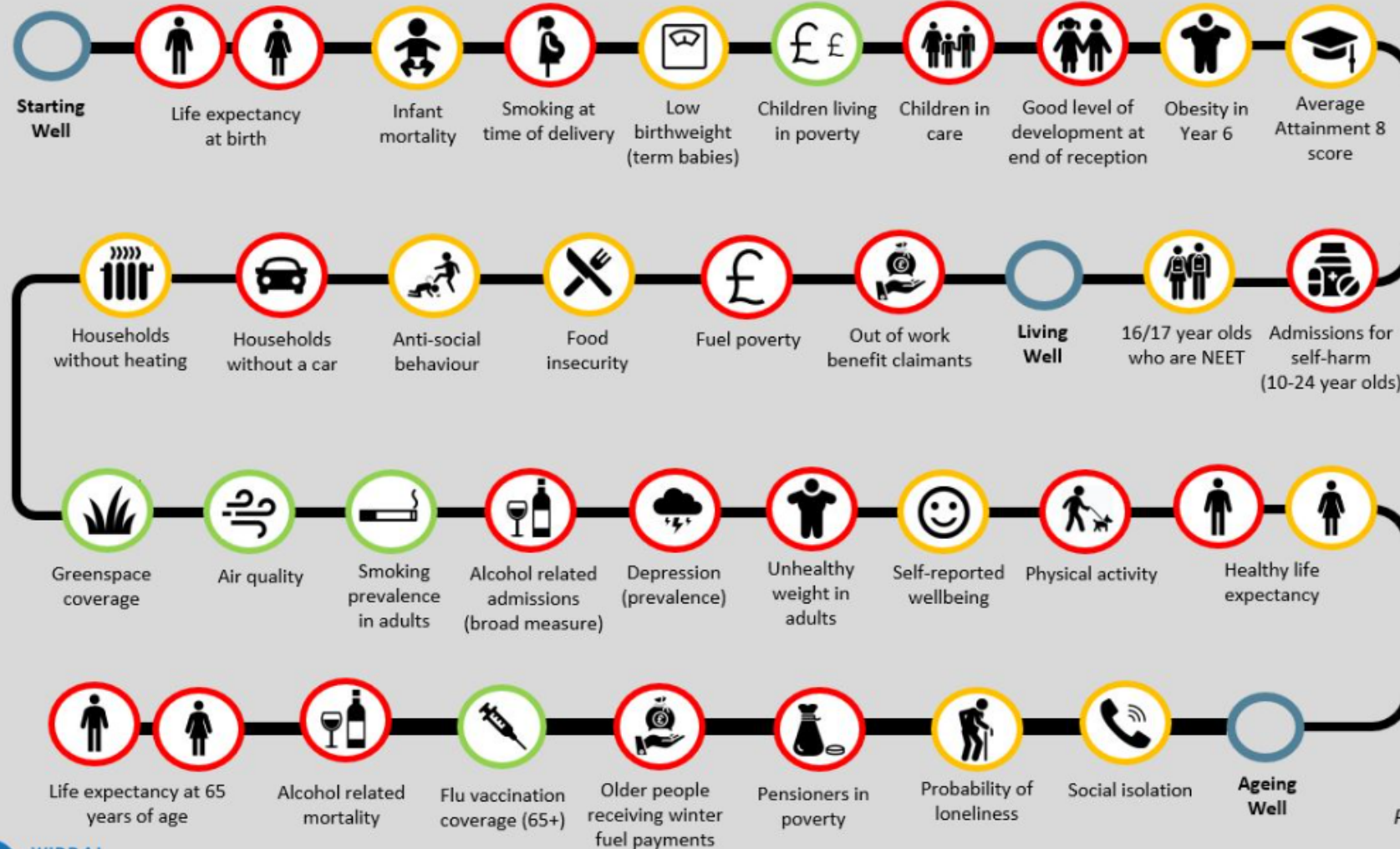
Percentage of Population by IMD Quintile



Wirral's Outcomes

Wirral life course statistics 2021

A comparison to England



Wirral Facts

Population
*About **324,000** people live in Wirral

Deprivation
35% of the Wirral population live in the top **20%** most deprived areas in England

Child Poverty
15% of children aged 0 to 15 live in poverty in Wirral

Key

- Statistical significance to England**
- Better
 - No significant difference
 - Worse

Produced by Wirral Intelligence Service

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LIFE EXPECTANCY

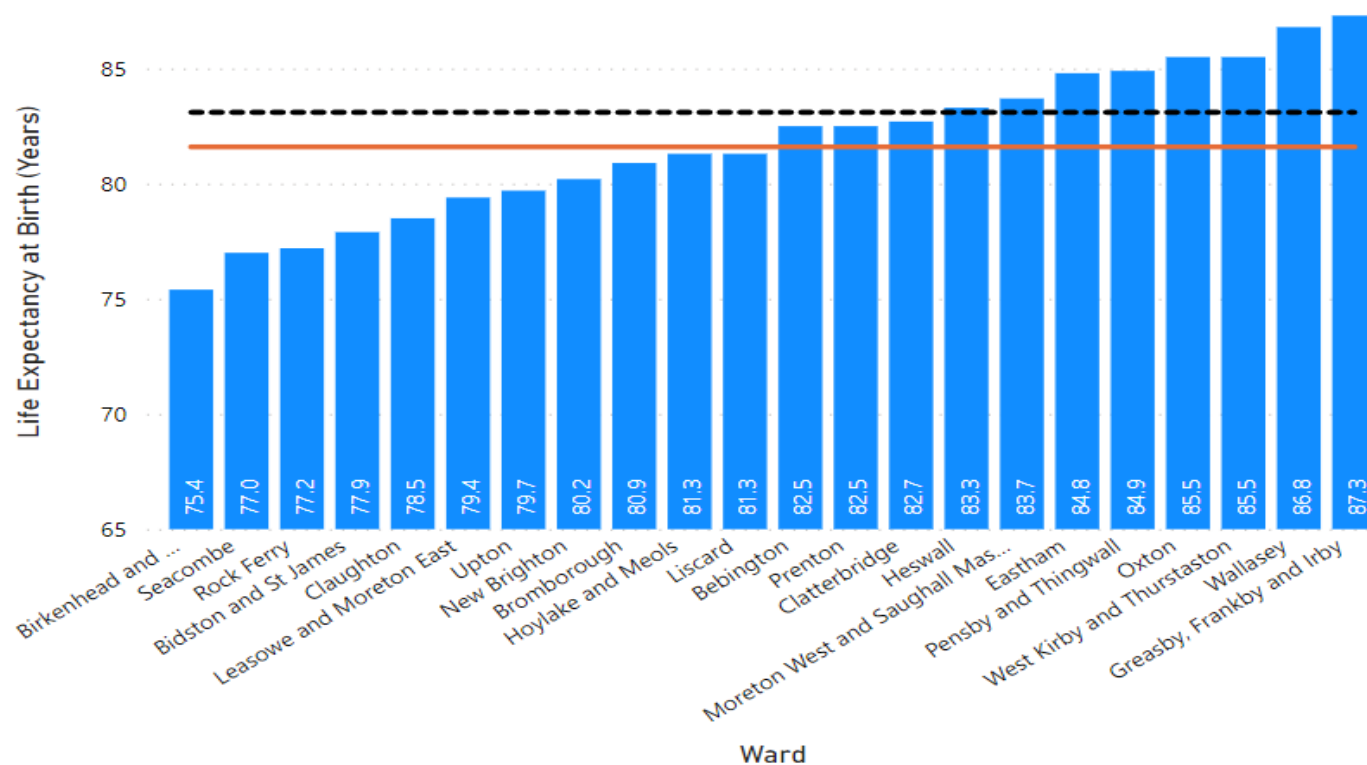
Female			Male		
2013-15	2014-16	2015-17	2016-18	2017-19	2018-20

[Click here to view Trend](#)

Life Expectancy at Birth by Ward

Wirral Life Expectancy

● Life Expectancy ● England ● Wirral



81.6

England Life Expectancy

83.1

Gap in Life Expectancy between Quintile 1 and Quintile 5

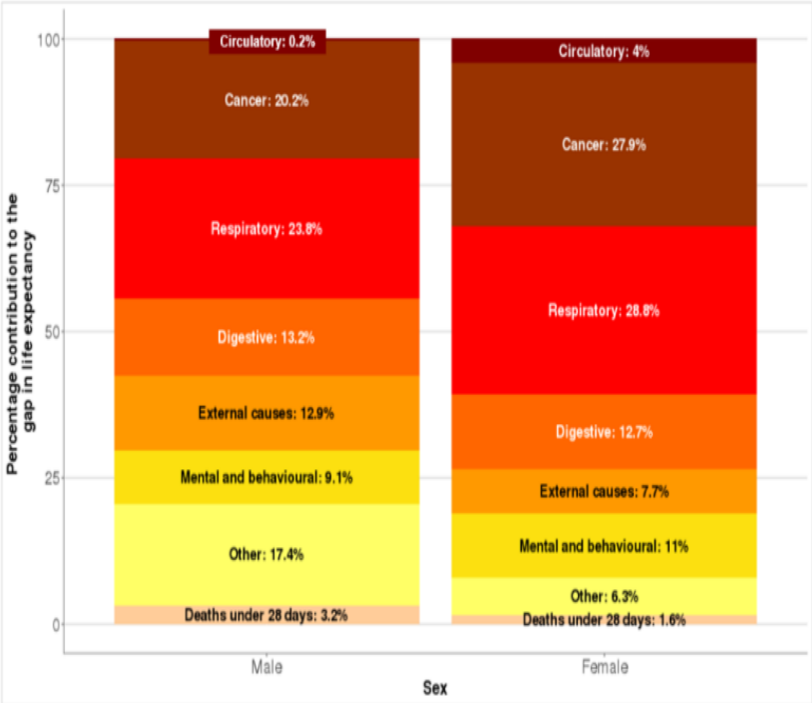
8.5 years

Gap in Life Expectancy between Decile 1 and Decile 10

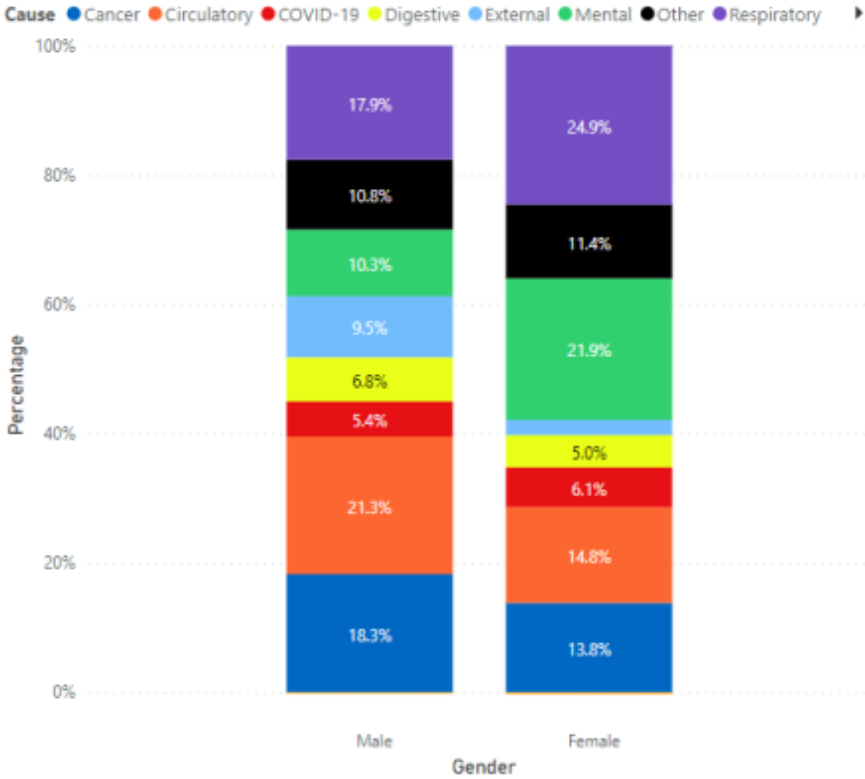
10.0 years

The high burden of disease in deprived areas generates higher use of health and social care services, higher unemployment, and lower productivity.

Proportional (%) breakdown of the life expectancy gap between Wirral and England, by broad cause of death (2015-17)



Life expectancy gap between most deprived and least deprived quintile by cause



The chart on the left shows in 2018-20, the gap in life expectancy between quintile 1 and quintile 5 by cause.

For males, the gap was 9.7 years. The main causes of excess deaths in quintile 1 that contributed to this gap are:

- Circulatory conditions 21.3%
- Cancer 18.3%
- Respiratory conditions 17.9%

For females, the gap was 8.5 years. The main causes of excess deaths in quintile 1 that contributed to this gap are:

- Respiratory conditions 24.9%
- Mental & behavioural causes 21.9%
- Circulatory conditions 14.8%

Wirral Health Inequalities Electoral Ward Profiles

Indicator																							Wirral	England
	Bebington	Bidston and St James	Birkenhead and Tranmere	Bromborough	Clatterbridge	Cloughton	Eastham	Greasby, Frankby and Irby	Heswall	Hoylake and Meols	Leasowe and Moreton East	Liscard	Moreton West and Saughall Massie	New Brighton	Oxton	Pensby and Thingwall	Prenton	Rock Ferry	Seacombe	Upton	Wallasey	West Kirby and Thurstaston		
Total Population	15,669	16,256	16,926	16,427	13,986	14,201	14,195	13,728	13,126	13,451	15,086	16,086	13,958	15,162	13,784	13,024	14,786	14,751	15,609	16,924	14,658	12,543		
Population aged 65 years and over	3,375	2,340	1,948	3,021	4,146	3,244	3,392	4,058	4,374	3,602	2,785	3,012	3,402	3,336	3,325	3,775	3,067	2,251	2,066	3,633	3,535	3,602		
Black and Minority Ethnic Population (Census, 2011)	683	836	1,682	659	512	831	410	487	653	723	648	768	476	922	835	460	735	820	846	764	587	764		
IMD Score, 2019	17.1	60.6	61.5	30.8	11.4	37.3	17.9	9.5	6.3	12.2	39.3	39.1	24.8	32.0	21.3	15.3	23.5	54.2	58.0	33.8	15.6	12.6	29.6	21.7
Income deprivation, IMD 2019	9.9	37.7	36.7	16.7	6.5	21.1	9.9	6.0	4.3	7.4	23.5	21.1	14.7	18.0	11.6	9.9	13.6	33.2	33.8	20.8	8.9	7.6	17.4	12.9
Older people in Poverty, English Indices of Deprivation, 2019	10.6	36.3	40.1	17.9	7.4	21.8	12.1	7.4	5.1	8.9	25.6	21.5	18.0	19.7	13.2	13.7	15.7	29.9	31.4	22.3	11.6	9.1	16.6	14.2
Child Poverty, English Indices of Deprivation, 2019	11.7	45.2	41.1	20.0	5.9	24.9	11.5	5.7	4.0	5.6	29.2	25.8	18.2	20.2	11.2	8.3	13.8	41.9	41.5	25.6	9.6	6.4	21.8	17.1
GCSE Achievement	73.9	44.1	37.4	62.2	72.8	54.5	57.2	69.5	79.9	73.0	46.7	48.9	59.3	49.5	64.2	69.3	68.7	53.1	39.2	53.1	61.1	76.9	59.1	56.6
Fuel Poverty, 2020	13.1	23.2	22.4	16.0	9.3	15.8	11.1	8.4	8.0	11.1	16.0	17.7	11.0	15.2	10.8	10.7	13.6	22.1	21.7	13.8	11.7	9.0	14.4	13.2
Emergency hospital admissions in under 5s	173.8	183.1	190.7	176.4	202.2	197.0	174.0	168.6	142.8	171.4	187.5	176.8	199.4	151.9	224.1	139.9	183.0	214.9	211.4	198.0	163.5	123.0	182.9	140.7
Emergency hospital admissions for injuries in under 5 years olds	108.0	163.7	174.0	97.5	112.8	155.2	117.6	122.4	80.5	125.1	140.4	130.4	129.2	131.1	102.8	120.6	120.7	140.5	152.6	120.7	112.4	109.5	130.8	119.3
Emergency hospital admissions for injuries in under 15 years old	82.1	130.0	124.7	82.0	80.8	119.1	87.3	89.8	73.9	92.2	110.3	111.7	89.9	107.4	104.5	99.0	78.4	110.7	105.4	111.5	72.8	81.7	99.9	92.0
Emergency hospital admissions for injuries in 15 to 24 years old	127.0	219.2	326.9	160.8	82.1	196.3	119.6	106.7	102.5	126.1	192.2	165.3	183.5	163.1	171.7	141.0	171.6	259.3	175.7	188.6	122.9	156.0	174.0	127.9
Emergency hospital admissions for intentional self harm	95.7	214.8	302.8	128.4	64.3	210.1	109.3	53.7	85.2	82.7	153.9	162.9	134.8	163.3	126.8	98.0	126.5	227.9	229.2	168.0	68.5	94.0	147.9	100.0
Emergency hospital admissions for all causes, all ages	107.2	176.2	180.7	127.9	101.8	148.4	112.4	94.7	84.9	102.8	150.7	134.2	125.3	122.5	122.5	104.9	120.3	180.2	165.2	137.2	96.2	94.1	125.5	100.0
Emergency hospital admissions for coronary heart disease	109.2	151.3	154.3	105.4	84.3	118.2	111.5	100.2	77.3	82.1	127.0	115.1	127.3	98.9	117.7	101.7	93.8	151.6	164.9	118.4	92.2	85.3	110.0	100.0
Emergency hospital admissions for Myocardial Infarction (heart attack)	66.5	108.3	120.3	79.2	62.7	88.2	75.7	84.7	69.6	70.9	101.7	85.0	85.8	68.3	96.7	71.3	73.5	91.6	126.6	105.0	73.0	67.7	83.3	100.0
Emergency hospital admissions for stroke	89.9	125.4	143.9	94.9	84.9	101.1	85.5	74.1	81.8	79.9	131.4	110.5	79.2	88.0	97.8	90.7	86.4	118.1	152.5	87.4	69.3	84.0	94.6	100.0
Emergency hospital admissions for hip fracture in 65+	79.3	145.2	122.3	107.5	106.8	112.9	79.6	69.0	79.3	101.5	128.7	109.6	89.1	115.6	133.3	74.0	89.9	156.6	119.2	101.8	67.0	78.0	99.0	100.0
Incidence of all cancers	111.4	134.6	113.9	104.8	103.9	104.7	118.3	102.3	101.4	100.1	118.8	101.9	116.1	100.5	103.0	115.5	111.0	130.3	119.4	109.6	100.9	102.1	109.3	100.0
Incidence of breast cancer	109.6	79.6	89.4	97.6	103.0	98.3	114.4	104.2	114.7	129.8	92.0	83.9	106.2	99.0	117.8	133.6	115.6	82.8	84.5	114.5	98.7	114.5	104.8	100.0
Incidence of colorectal cancer	119.9	135.4	100.8	93.9	108.6	104.6	126.1	111.2	114.9	113.7	136.6	89.9	144.8	104.8	98.8	113.4	121.3	104.3	156.5	96.3	103.0	100.0	112.8	100.0
Incidence of lung cancer	97.7	204.0	222.5	121.5	74.7	112.3	109.8	74.1	53.3	69.4	150.1	146.4	126.1	132.0	98.2	90.6	115.2	171.8	180.5	125.0	82.8	78.7	112.8	100.0
Incidence of prostate cancer	108.8	93.6	52.6	89.0	117.5	86.9	107.8	108.8	105.9	101.8	99.3	78.1	74.9	66.0	115.2	119.7	110.3	98.8	69.4	86.6	94.7	101.8	96.3	100.0
Deaths from all cancer, all ages	99.6	157.2	140.6	108.5	103.6	106.9	114.8	93.9	90.2	99.9	128.0	112.8	108.9	115.3	96.5	101.6	95.6	144.4	142.4	110.7	97.0	87.1	108.6	100.0
Deaths from all cancer, under 75 years	91.8	188.4	165.5	113.8	91.4	111.7	122.0	79.4	73.1	94.0	143.8	127.7	105.0	105.2	104.8	95.0	112.3	151.8	160.0	121.8	96.1	82.7	112.5	100.0
Deaths from all causes, all ages	109.6	164.4	166.1	121.7	104.8	140.7	94.0	74.4	85.1	107.1	122.9	131.7	101.2	123.4	92.0	85.9	100.0	164.5	156.1	122.2	81.1	79.9	110.3	100.0
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Deaths from causes considered preventable, under 75 years	96.6	266.9	293.2	128.4	68.4	118.5	111.7	65.8	51.0	75.7	159.6	159.6	115.7	124.9	88.4	71.9	113.4	214.6	219.8	151.7	82.8	69.6	124.7	100.0
Deaths from circulatory disease, all ages	92.8	138.5	145.1	117.4	90.6	110.5	86.3	71.6	81.9	85.8	125.2	114.2	99.0	111.1	81.9	79.7	90.9	118.9	154.9	92.4	84.7	74.8	97.8	100.0
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Deaths from coronary heart disease, all ages	89.6	155.1	158.4	119.7	80.3	95.6	83.3	71.6	69.7	78.7	120.7	107.7	89.2	101.6	80.2	87.2	91.1	118.9	161.4	83.8	77.9	60.0	93.9	100.0
Deaths from respiratory diseases, all ages	120.1	232.0	203.7	140.6	97.2	156.8	116.3	72.0	78.5	104.5	181.2	164.5	132.2	151.9	96.8	82.6	131.8	211.8	207.9	150.5	88.4	76.2	126.8	100.0
Deaths from stroke, all ages	93.7	104.7	123.7	118.4	105.0	142.1	102.2	78.6	84.1	89.7	147.4	147.0	94.3	161.6	91.8	75.1	112.0	131.4	142.3	100.0	82.2	99.8	107.0	100.0

Our Proposed Refreshed Model

Community power is not a model that can be simply transferred from place to place. Its evolution is determined by the particular communities who ultimately should influence and lead decisions and the nature of support.

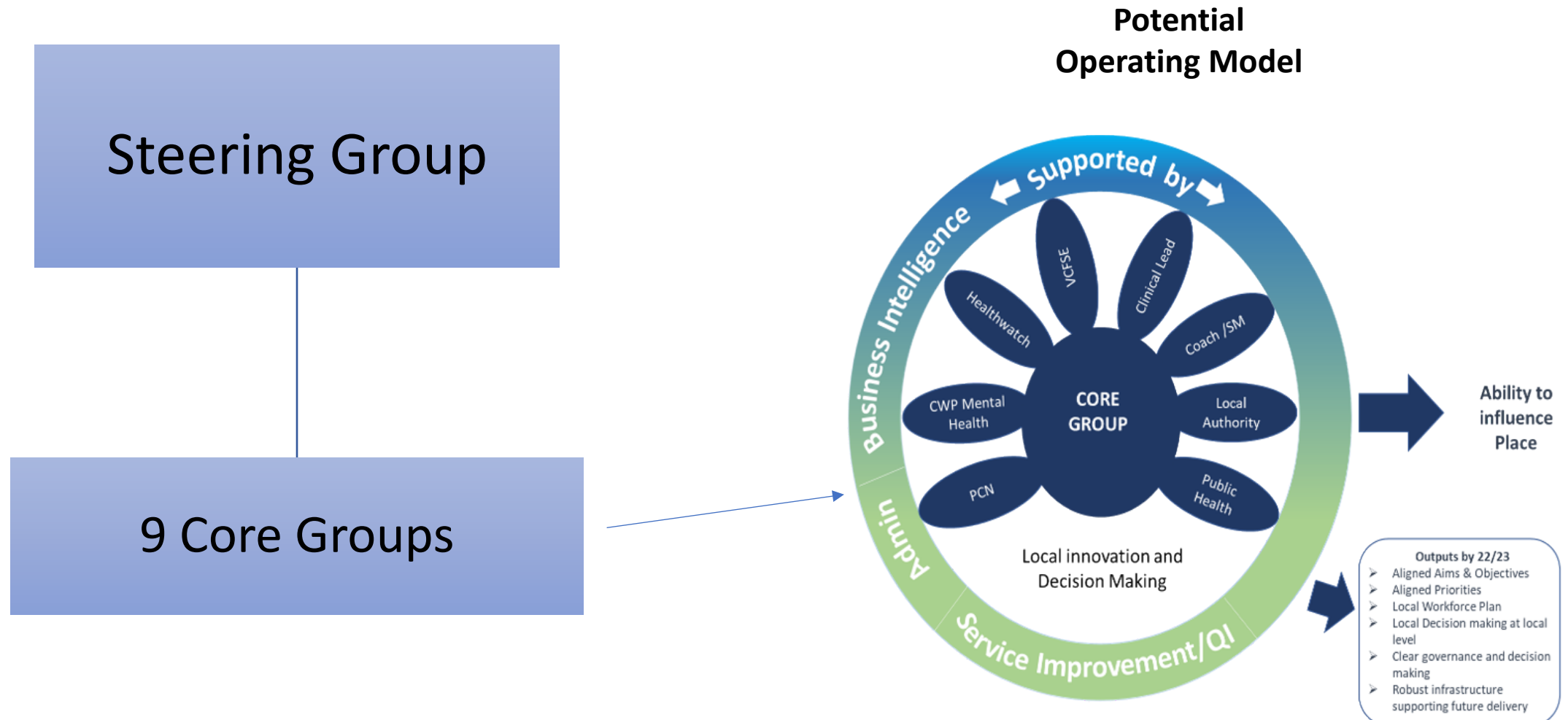
- Neighbourhoods Care Communities will form the foundation for how we on Wirral and our health and care system will tackle health inequalities
- It will be led by community leaders - bottom up approach to tackling health inequalities.
- Population health and local intelligence joined – focus on deep local insight
- Each Neighbourhood will decide their particular priority to focus on
- Enable the change – principle to test out as long as you don't bankrupt or cause harm – transformation funding for each neighbourhood
- Relationships in the neighbourhood are key
- Work will be prevention focused – wider determinants and clinical approach
- Community participation in decision-making
- Understand the neighbourhood to ensure there is a community asset approach
- Our aim to move to community paradigm

Three NHS paradigms: state, market and community

The NHS	State paradigm	Market paradigm	Community paradigm
Key organisational principle	Standardisation	Efficiency	Prevention
Key problems seeking to solve	Treating illness	Treating illness more efficiently	Preventing illness, alongside treatment when needed
Locus of power	Clinician and Whitehall bureaucrat	Clinician and manager	Clinician and community
View of service user	Deficit-led: primarily a passive patient	Transaction-led: a customer with choice determined by provider	Asset-led: a participant in their own health and wellbeing
View of communities	Not in the purview of services	A source of treatment alternatives through social prescribing	Equal partners with deep insight into effective service response
Implementation method	Top-down, uniform model of provision	Targets, performance management and productivity drives	Devolution, culture change and deep community engagement
Organisational relationships	Separate specialist organisations	Competition between organisations	Collaboration and shared community-led mission across organisations
Funding model	Centrally planned funding model	Activity-based funding model	Place-based funding allocations, joint investment in prevention
Accountability	Whitehall	Whitehall, across an increasing number of arms-length bodies	Local accountability in the context of a national outcomes framework
Approach to engagement	Not widely pursued	Patient feedback sought through closed surveys	Community participation viewed as essential to service design
Attitude to data	Quantitative data informs decision-making at the top	Quantitative data informs performance management within different services	Quantitative data, combined with qualitative community insights, informs prevention shift

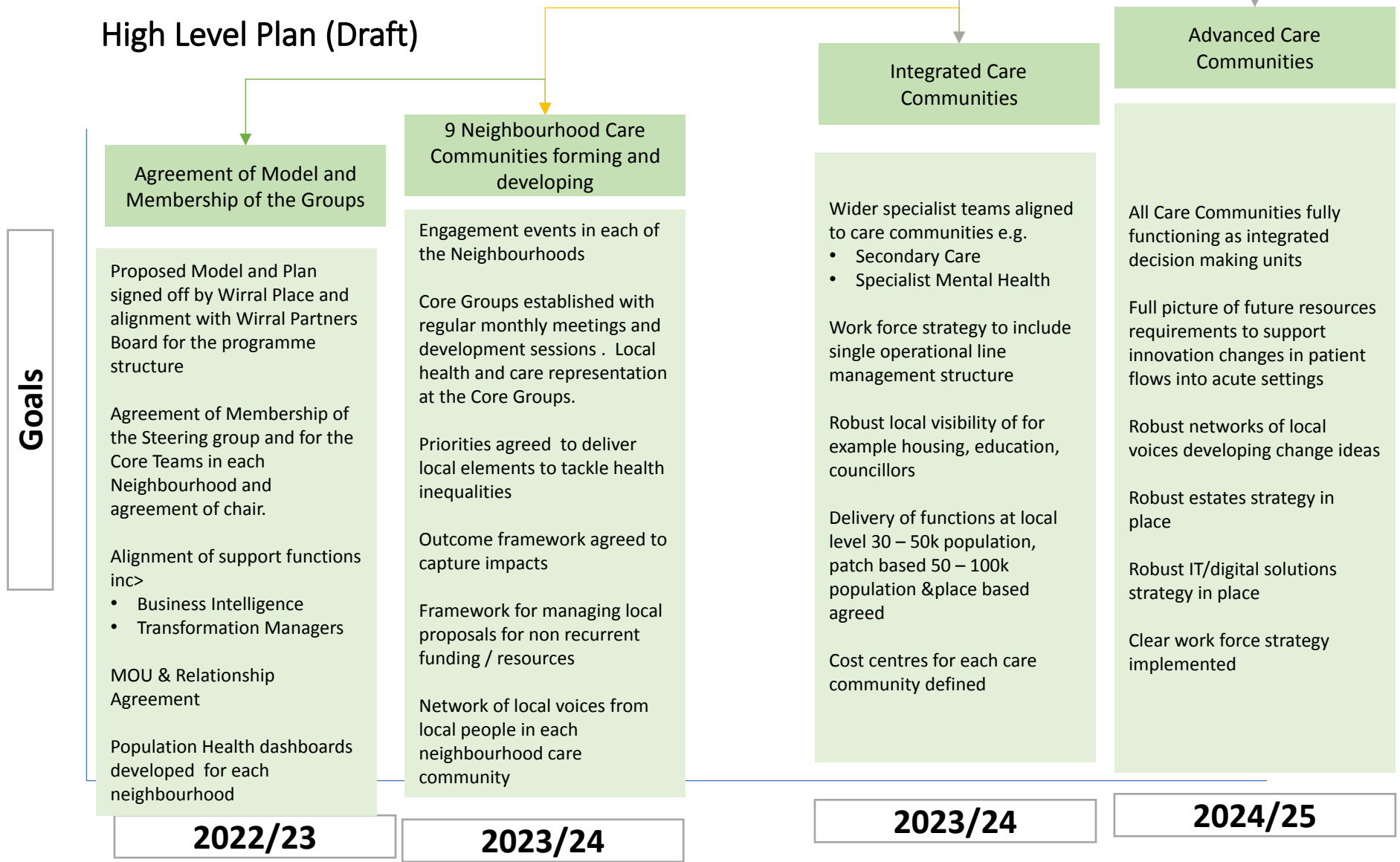
These key to our principles

Our Proposed Model



High Level Programme Time Line

This potential future model will need agreement by Wirral Place



What we need to develop now

- Steering Group and Core group membership to be agreed and start to meet monthly – need to identify support from Place management team
- Relationships are key and the bottom up approach – must allow time for this
- Get champions ‘shiny stars’ and GP champions
- Identify if there is potential to start with two communities – prototypes
- Support with quality improvement/ service improvement resource
- Engagement events in each neighbourhood – Eastern Cheshire had up to 157 people
- Population health dashboards for each – including activity eg ED attendance etc.
- Have a relationship document which outlines the specific objectives of each care community and the governance
- Everyone has to accept the model – this is how we work here - growing a community-focused organisational culture across all organisations in Wirral
- Measure maturity of each core group as we progress
- Name the neighbourhoods!

Primary Care Networks With GP Neighbourhood Boundaries

