Health Inequalities Annual Report
April 2010

1. Introduction

This report provides an annual update on the progress towards meeting national and local targets for health inequalities. It also reports on the actions and strategic objectives set out in the Health Inequalities Action Plan (HIAP) which was agreed in June 2009 by Wirral Strategic Partnership.

The report presents performance data on the health inequalities targets set for Wirral. The data are drawn primarily form Wirral's Joint Strategic Needs Assessment which is available with further data and analyses at www.info.wirral.nhs.uk It analyses progress on overall outcomes and on contributory programmes and factors that influence health and well-being. These are reported against the three timescales set in the HIAP; 2011, 2013 and 2025 and accordingly, the progress report is split into three sections.

A full account of progress, made by designated lead agencies and individuals, against all actions contained within the HIAP is attached at Appendix one. This is summarised within the relevant sections of this report.

The report summarises the progress and identifies risks to meeting targets. It makes recommendations on the areas of focus for the next 12 months to ensure that impact is maximised.

2. Executive summary and recommendations

2.1 Summary of recommendations

This summary collates overarching recommendations from the review of data on health inequalities and the report on the HIAP. Further information on recommendations is detailed throughout the report.

- The Health and Well-being Partnership Co-ordination Group should review the HIAP annual report and hold to account the leads for each incomplete action. They should seek clarification on why actions are incomplete and to what extent this has impacted on potential achievement of targets. Revised plans should be set in place to prioritise achievement of all the actions that are still felt to be critical. This should initially focus on those actions set in place to achieve health outcome one, due to the short time frame (December 2011).

- 50% of all actions in the HIAP are green (completed or on track for completion within timescale). Consideration should be given to which of these could be 'stretched' to achieve a higher impact on health inequalities.

- Networks that are in place to support the 3rd sector should be utilised to engage a larger range of organisations and groups in determining future actions to reduce health inequalities.

- The report; *Fair Society, Healthy Lives; a Strategic Review of Health Inequalities in England post 2010* should be used as a basis for reviewing and agreeing targets and actions to achieve longer term reduced health inequalities.

- A core data set should be established to provide interim monitoring of progress towards achieving health inequalities targets. These should include monitoring points for all three HIAP health outcomes. The data set should include interim measures to track progress on employment, education, child poverty, benefits, morbidity and mortality of major health causes of death in the most deprived quintile of Wirral, infant mortality, substance misuse, lifestyle behaviours and wellness, suicide and undetermined injury and accidents. The data set should focus on the difference in these measures between England, Wirral and specific groups with the worst experience in relation to each.

2.2 Summary of progress on health outcome 1

Outcome 1 is a reduction in the inequalities gap between Wirral and England by 2010. Whilst performing adequately on infant mortality, Wirral is not on track to meet the overarching life expectancy target which has in fact, increased. Increased life expectancy in a short time frame requires a focus on groups of people with a high level of known risk factors for the main causes of premature death. Progress in each of the main causes is as follows:

- In recent years, Wirral has had a lower infant mortality rate than for England

- AAACM – the gap has reduced slightly for men but as rates have fluctuated, this does not demonstrate a reducing trend. The gap for females has widened in the last two time periods against a previous trend of reduction.

- <75 years CVD mortality – the gap between Wirral and England has reduced with female mortality falling below the England rate.

- The excess winter deaths index in Wirral was lower in 2008/9 than in the baseline year but the rate fluctuates.

- COPD – the gap between Wirral and England has increased for both males and females. The general trend for females is an increase in COPD mortality.

- Cancer – the gap between Wirral and England has reduced in males but increased in females.

- Suicide and undetermined injury – the gap between Wirral and England has increased although the overall mortality rate has declined.

- Mortality from chronic liver disease – the gap between Wirral and England has increased and is a main contributor to Wirral's failure to meet the life expectancy target.

The HIAP progress shows that of the 34 actions that have been set to contribute to the achievement of outcome one, 18 (53%) are now green (completed or on track for completion within timescale). There are 14 actions that are amber (41%) and 2 that are red (6%). The actions that remain red require the following:

- 1.3 action B - Number of households assisted with energy efficiency measures – the number of households assisted has decreased due to changes in availability of Government grants. Consideration should be given to the impact this will have on inequalities and if alternative arrangements can be made.

- 2.9 relates to revascularisation equity of access and rate of procedure. Revascularisation rates are being benchmarked and when available, should be used to assess if Wirral are in the top decile for performance and if further action needs to be taken.

Further actions that should be considered a priority that are currently amber are:

- The number of households assisted with energy efficiency measures is declining and may adversely impact on health inequalities.

- People at high risk of death in winter should be identified and measures set in place to ensure they have a lead case manager, prior to winter 2010.

- Cancer and cardiovascular disease equity audits have been completed and recommendations should now be agreed and an action plan set in place for their implementation in time to impact on mortality by December 2011.

- Develop a clear partnership plan for reducing health inequalities in the most deprived areas (Health Action Area).

- Child accident prevention and children killed or seriously injured in road traffic accidents is progressing but further planning is required in order to improve performance

Many of the overarching targets are not yet demonstrating a reduction in health inequalities. However, data are not available up to the present time with most of the

mortality data being three year rolled (2006-2008). Indicators that can be measured annually are showing improvement and it is expected that these will begin to impact on overarching targets from 2008. These improving measures include alcohol hospital admissions, early identification and treatment of CVD, teenage conceptions, hospital admissions due to fractured neck of femur and numbers of people quitting smoking.

2.3 Summary of progress on health outcome 2

Health outcome 2 is a reduction in the gap in health inequalities between the different areas of Wirral by 2013. Two over arching measures are used to monitor progress which is as follows:

- The health inequalities gap between the most deprived areas and the rest of Wirral has increased rather than reduced as measured by mortality rates.

- The slope index of inequalities shows an increase in inequalities in Wirral in both males and females between 2001 and 2008.

Monitoring the incidence and death rates of the main causes of premature death for the whole of Wirral compared to those in the most deprived areas provides an indication of if we can expect the overarching measures previously discussed to improve. Progress against these main causes shows that the gap between Wirral and the most deprived areas has increased for CVD, Cancers, COPD, chronic liver disease and accidents. Only the gap in death rates from suicide and undetermined injury has reduced. The most significant increases in the gap are in chronic liver disease and accidents. In addition, death rates from COPD, chronic liver disease and accidents are getting higher in the most deprived areas showing that health is worsening in these areas.

The HIAP progress report shows that of the 22 actions agreed to impact on health outcome two, 12 (55%) are green, 10 (45%) amber and none are red. The actions that are not yet completed (amber) include:

- 1.2: increasing progress on supporting people to live independently.

- 2.12 / 2.13; complete the review of pharmacology supporting people to stop smoking and continue to improve success rates across all stop smoking service providers.

- 2.22; set in place a mechanism to identify patients on GP registers who are at risk of chronic ill health due to alcohol.

- 3.2; Utilise new networks to engage with the 3rd sector re planning to reduce health inequalities.

2.4 Summary of progress on health outcome 3

Health outcome 3 is an improvement in the underlying factors that cause health inequalities over the longer term. The factors include deprivation, child poverty, employment and educational attainment. Whilst wide variations in these factors are experienced in Wirral, health inequalities will continue to exist. The following is a summary of the position in relation to these factors:

- The indices of multiple deprivation figures will be updated later this year and will be used to determine if the improvement between 2004 and 2007 in Wirral has been maintained and further improvement gained.

- There was improvement between 2004 and 2007 in the income deprivation affecting children index. However, there were three Wirral areas within the top 100 worst nationally and lower super output areas (LSOAs) in Wirral are ranked from 51 to 32,291 (out of 32,482 LSOAs in England). There needs to be a focus on reducing the child poverty gap in designated deprived areas.

- Wirral is ranked 8th worst out of 354 districts for the employment domain of IMD. Unemployment and incapacity claimant levels demonstrate high levels of economic inactivity in the most deprived areas.

- Whilst educational attainment overall in Wirral is high, there are significant disparities between geographic areas and children in care and the rest of Wirral.

The HIAP progress shows that out of 14 actions to address outcome 1, three (21%) remain red, six (43%) amber and five (36%) green. The following is recommended in relation to the actions that are currently red:

- 4.4; the proportion of women continuing to smoke throughout pregnancy has risen over the last 12 months despite increased numbers of women successfully quitting with NHS stop smoking services.

- 1.6; action A – The proportion of people claiming out of work benefits has risen and continues to be affected by the recession.

- 1.6; action B – Programmes are in place to provide health improvement support to people claiming incapacity benefits but numbers into employment are low and require monitoring to judge impact on reducing the number of claims.

Further actions requiring attention that are currently amber include:

- 16-18 year olds not in education, training and employment, child obesity, child accident prevention and children killed or seriously injured in road traffic accidents is progressing but further planning is required in order to improve performance.

- Fit for purpose BME data collection in services – although some progress is being made, consistent data sets need to be included in contracts to ensure BME equity of access can be monitored.

3. Health Outcome Monitoring

3.1 Health Outcome 1: target timescale 2011

There are two national overarching Public Service Agreements to reduce health inequalities which are measured by three year rolled data from baseline to 2009/11 (known as the 2010 health inequalities targets). Data are included up to December 2011. The two targets are life expectancy and infant mortality.

Life expectancy

- To reduce by at least 10 per cent the gap in life expectancy between the fifth of local authority areas with the worst health and deprivation indicators (the Spearhead Group, including Wirral) and the population as a whole by 2010, from a baseline of 1995-97.

Wirral is currently not on target to meet the life expectancy target, with the relative gap having got 30% wider since the baseline year. Table 1 shows progress against this target since the baseline year.

Table 1:Life expectancy at birth in Wirral and England for 1995-97 - 2006-08

Time Period	England		Wirral		Gap (years)		Percentage (%) Change in Relative Gap from 1995-97 Baseline	
	Males	Females	Males	Females	Males	Females	Males	Females
1995-97	74.6	79.7	73.14	78.98	1.46	0.72	0.0%	0.0%
1996-98	74.8	79.8	73.54	78.76	1.26	1.04	-14.0%	45.4%
1997-99	75.1	80.0	73.81	79.05	1.29	0.95	-12.6%	33.1%
1998-00	75.4	80.2	73.87	79.21	1.53	0.99	3.4%	38.6%
1999-01	75.7	80.4	74.32	79.66	1.38	0.74	-7.2%	2.8%
2000-02	76.0	80.7	74.87	79.91	1.13	0.79	-24.5%	9.5%
2001-03	76.2	80.7	75.22	80.00	0.98	0.70	-34.6%	-2.5%
2002-04	76.5	80.9	75.39	80.16	1.11	0.74	-26.3%	2.3%
2003-05	76.9	81.1	75.50	80.23	1.40	0.87	-7.0%	19.6%
2004-06	77.3	81.6	75.70	80.78	1.60	0.82	5.3%	12.9%
2005-07	77.7	81.8	75.7	80.9	2.00	0.9	30.0%	22.2%
2006-08	77.9	82.0	75.9	81.0	2.00	1.00	30.0%	33.3%

Source: ONS 2009

It should be noted that life expectancy in Wirral has improved year on year since the baseline year for men and women but that this improvement has been less than that achieved for England as a whole.

Infant mortality

- To reduce by at least 10 per cent the gap in infant mortality between routine and manual groups and the population as a whole by 2010, from a baseline of 1997-99.

Wirral has had a lower infant mortality rate than England for the most recent time periods (see table 2). However, infant mortality is still higher in the most deprived areas than in Wirral, although this is subject to quite a high level of random variation and in the most recent time period, the gap reduced.

Table 2: Infant Mortality Rates per 1,000 in Wirral, 20% most deprived areas in Wirral, and England, 1999-2007 (3-year rolling rates)

Area	1999-01	2000-02	2001-03	2002-04	2003-05	2004-06	2005-07	2006-08
England	5.57	5.43	5.33	5.23	5.13	5.03	4.94	4.82
Wirral	6.03	4.77	4.03	4.13	5.13	4.87	4.70	4.52
20% most deprived Wirral	7.36	5.72	4.19	5.34	7.61	8.81	6.39	5.25

Source: NCHOD (England rates). Wirral rates calculated from ONS Annual Birth & Death Extracts.

3.1.1 Interim monitoring for outcome 1

Improving overall life expectancy within a short time frame requires action to prevent premature mortality. It is difficult to identify which individuals within a population might die prematurely from unexpected causes. Therefore, the focus is on improving health outcomes and prolonging life in those people with existing high risk factors such as progressive or unstable disease.

To achieve health outcome 1, the HIAP identifies the main risk factors and actions to reduce premature mortality. The impact of these actions, if successful, will lead to changes in the overarching measure; all age all cause mortality (AAACM - which is a proxy indicator for life expectancy and can be calculated for relatively small populations on a frequent basis). Positive progress will also be shown if Wirral deaths rates compared to England for cardiovascular disease (CVD), excess winter deaths, chronic obstructive pulmonary disease (COPD), liver disease, cancers, suicide and undetermined injury are improved.

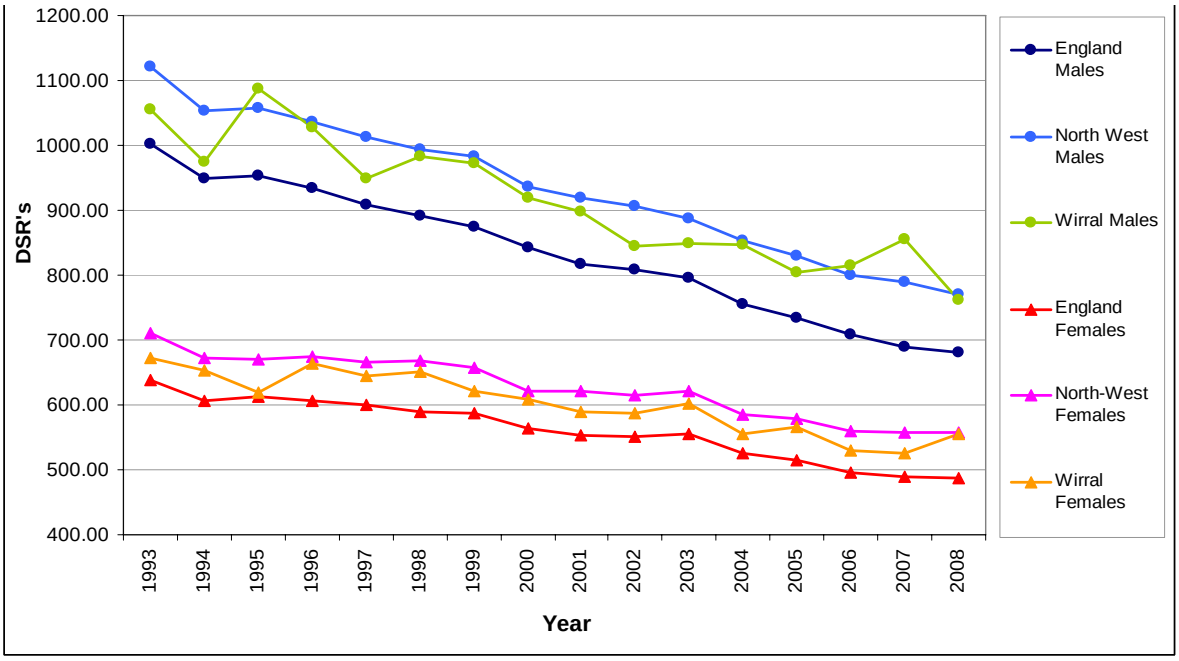
The following sections examine progress in Wirral compared to England for the main causes of premature mortality.

AAACM

AAACM rates are three-year average, directly age- and sex- standardised death rates per 100,000 of the population for all ages and all causes of death. Figure 1 shows AAACM in Wirral over fifteen years by gender, compared to the North West and England. This shows that for men, there has been an improvement in the last time period, when the gap between Wirral and England reduced (against baseline year 1996). However, this was not the case for the previous two time periods and should be interpreted with caution as may not indicate a trend.

The gap between Wirral and England for female AAACM has varied over the years but the general trend has been a reduction. However, in the last two time periods this has reversed with the gap widening.

Figure 1: All Age, All Cause Mortality, Directly Standardised Rates for Wirral, North-West & England, 1993 to 2008, by gender



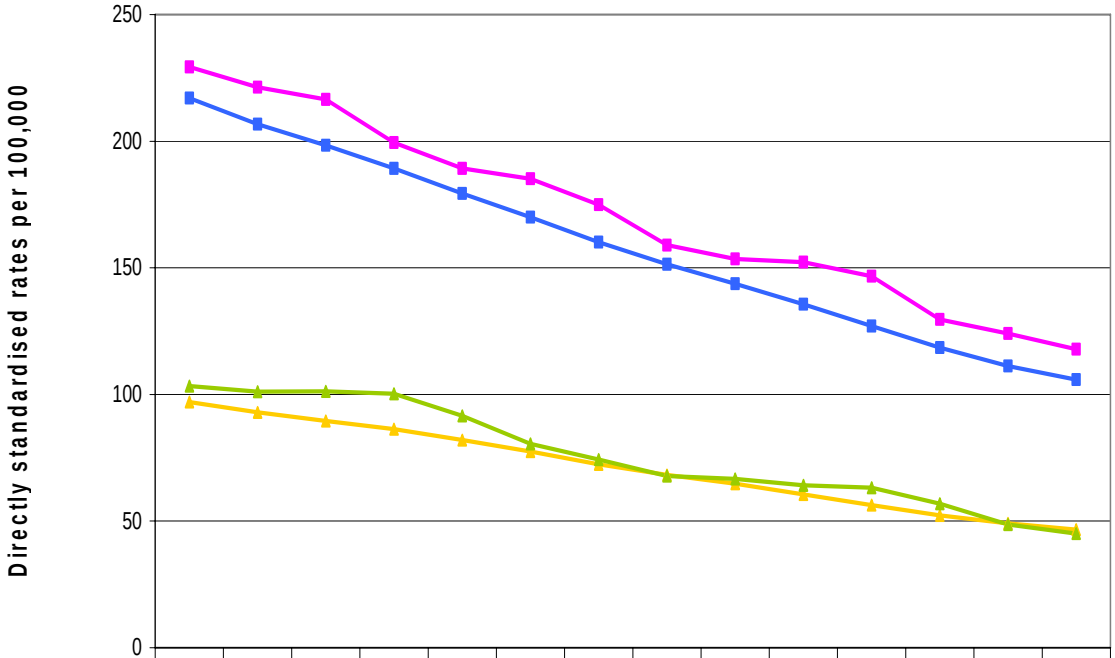
Source: NCHOD, 2009

CVD

Cardiovascular disease (CVD) includes diseases of the heart and circulation, including coronary heart disease (angina and heart attack), and stroke. Cardiovascular disease is the most common cause of death in the UK.

Overall, since 1993, Wirral has made considerable improvements in reducing mortality from CVD. Compared to baseline year 2005/07, the gap between England and Wirral for males has reduced. This is also the case for women and for the last two time periods, the Wirral death rate for females has been below that for England.

Figure 2: Under 75's CVD mortality rate per 100,000: Wirral and England (1993-2008)
Source: NCHOD, 2009



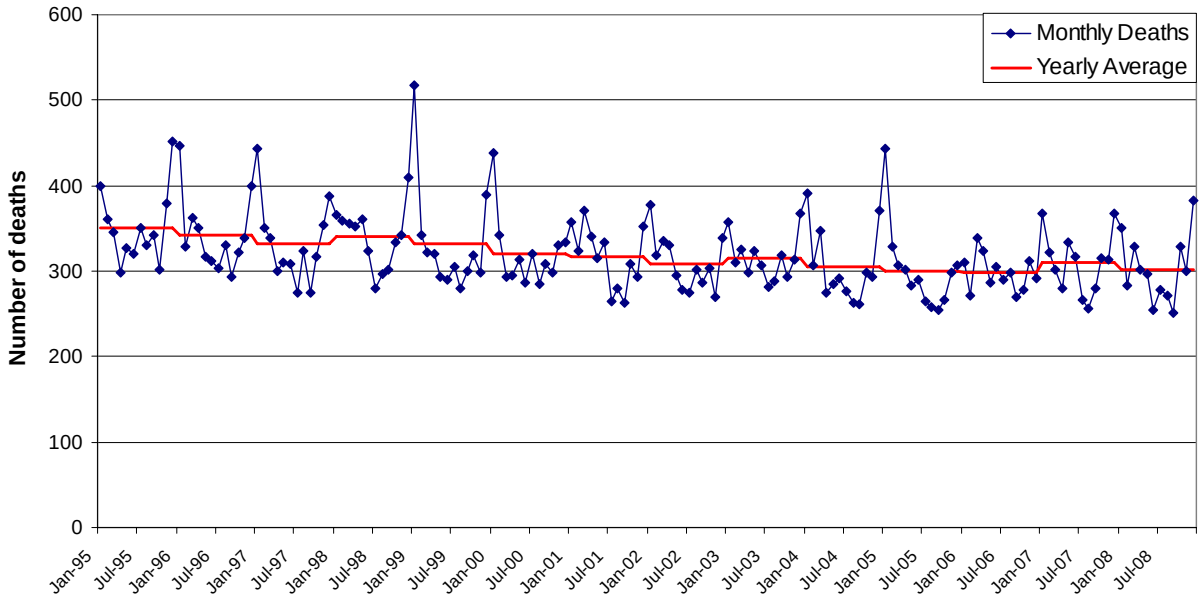
	1993-1995	1994-1996	1995-1997	1996-1998	1997-1999	1998-2000	1999-2001	2000-2002	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008
England (males)	217	206.64	198.35	189.21	179.32	169.99	160.15	151.39	143.69	135.6	127.05	118.43	111.19	105.83
Wirral (males)	229.3	221.34	216.47	199.46	189.23	185.14	174.93	158.98	153.44	152.22	146.61	129.59	124.08	117.89
England (females)	96.99	92.94	89.59	86.33	81.96	77.46	72.47	68.28	64.81	60.56	56.38	52.22	49.05	46.7
Wirral (females)	103.36	101.16	101.22	100.28	91.62	80.55	74.33	67.78	66.66	64.15	63.18	56.84	48.70	45.14

Source: NCHOD, 2009

Excess winter deaths

The excess winter death index (EWDI) is the number of excess winter deaths expressed as a percentage of the average of the non winter deaths. Although the causes are likely to be multiple, there are risk factors that can be identified in advance in order to plan prevention measures. Figure 3 shows that the EWDI was lower in 2008/09 (17.3%) than in the base line period 1995/97 (17.7%). However, the annual figure fluctuates and was at its lowest in 2000/01 (8.6%) and 2006/07 (11.4%).

Figure 3: Seasonal variation in all cause mortality in Wirral alongside the mean number of deaths for that calendar year



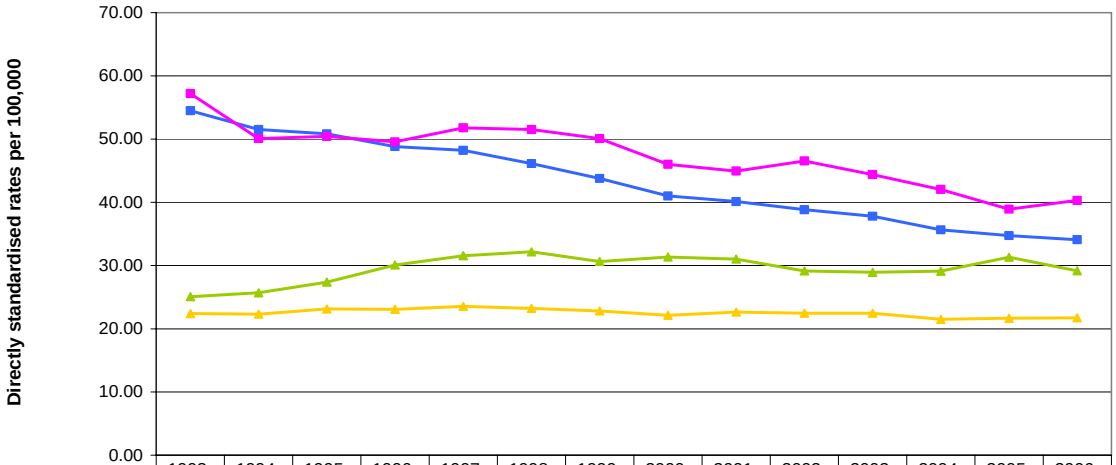
Source: ONS Annual Deaths Table, 2009

COPD

COPD is a general term and includes chronic bronchitis and emphysema. The main risk factor for COPD is smoking.

Figure 4 shows that the gap between England and Wirral for COPD mortality has increased since the baseline period. In addition, whilst the general trend for men has been a reduction, this has not been the case in the most recent time period. For women, the general trend has been an increase in mortality from COPD. In 2006-08, deaths from chronic obstructive airway disease and other respiratory diseases combined accounted for 15.3% of female deaths and 13.8% of male deaths (1,599 deaths).

Figure 4: Trend in COPD Mortality: All ages, Wirral and England (1993-2008)



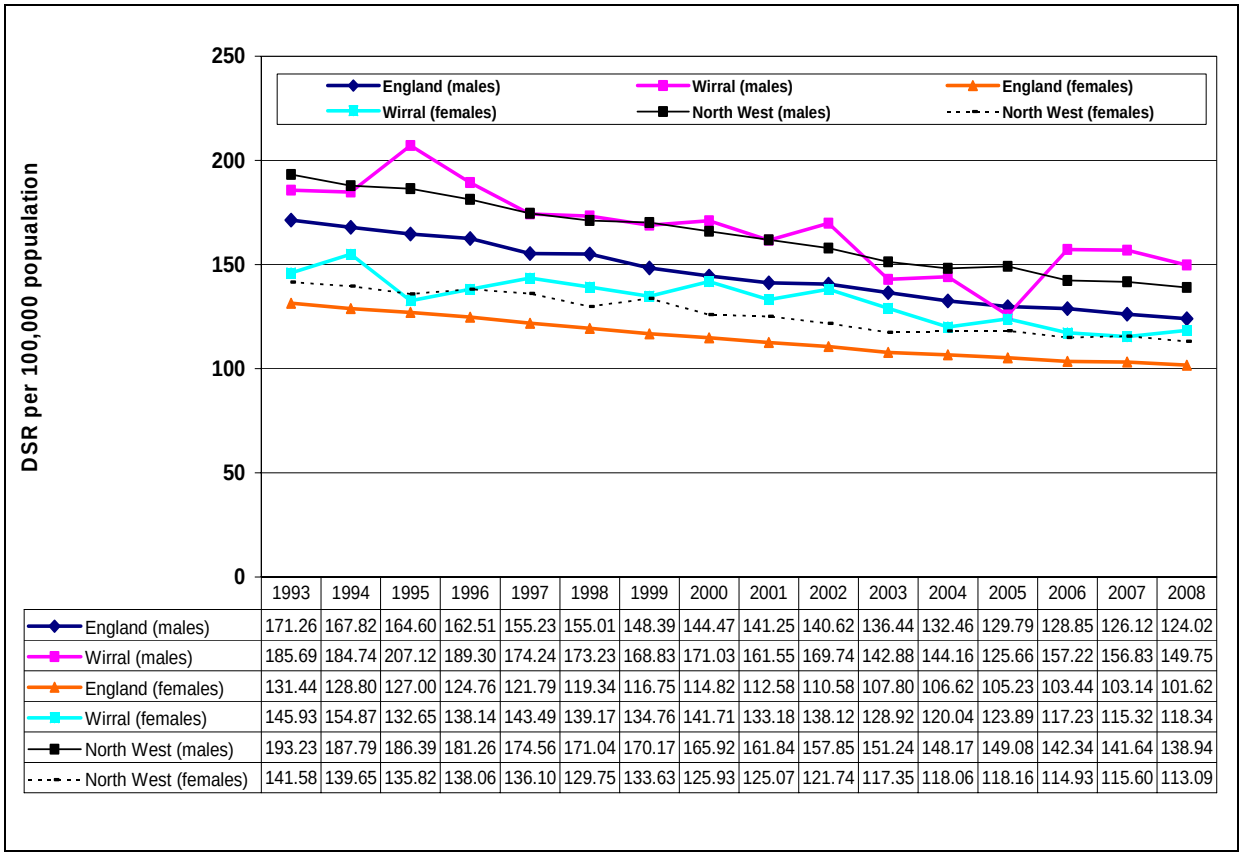
	1993-1995	1994-1996	1995-1997	1996-1998	1997-1999	1998-2000	1999-2001	2000-2002	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008
England (males)	54.49	51.51	50.84	48.82	48.20	46.12	43.77	41.01	40.14	38.83	37.79	35.66	34.74	34.09
Wirral (males)	57.19	50.06	50.42	49.56	51.78	51.53	50.08	46.02	44.96	46.54	44.38	42.03	38.92	40.29
England (females)	22.41	22.32	23.12	23.09	23.54	23.24	22.81	22.13	22.63	22.46	22.45	21.50	21.66	21.72
Wirral (females)	25.08	25.71	27.38	30.08	31.55	32.19	30.64	31.35	31.02	29.14	28.93	29.12	31.33	29.18

Source: NCHOD, 2009

Cancer

Of the six main causes of death in Wirral, cancer accounts for the most deaths in both men and women (in actual numbers). The death rate (premature – under 75 years) from all cancers has fluctuated but has been declining. Although cancer deaths in males rose sharply in 2006, there has been a reduction in the gap in the mortality rate between Wirral and England since the baseline year 2006 (26.9 to 25.73). In women, the gap has widened (13.38 to 16.75) and female mortality rose in 2008 (see figure 5).

Figure 5: All Cancer Mortality Trend by sex, Under 75 yrs: England, North West & Wirral, 1993-2008



	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
England (males)	171.26	167.82	164.60	162.51	155.23	155.01	148.39	144.47	141.25	140.62	136.44	132.46	129.79	128.85	126.12	124.02
Wirral (males)	185.69	184.74	207.12	189.30	174.24	173.23	168.83	171.03	161.55	169.74	142.88	144.16	125.66	157.22	156.83	149.75
England (females)	131.44	128.80	127.00	124.76	121.79	119.34	116.75	114.82	112.58	110.58	107.80	106.62	105.23	103.44	103.14	101.62
Wirral (females)	145.93	154.87	132.65	138.14	143.49	139.17	134.76	141.71	133.18	138.12	128.92	120.04	123.89	117.23	115.32	118.34
North West (males)	193.23	187.79	186.39	181.26	174.56	171.04	170.17	165.92	161.84	157.85	151.24	148.17	149.08	142.34	141.64	138.94
North West (females)	141.58	139.65	135.82	138.06	136.10	129.75	133.63	125.93	125.07	121.74	117.35	118.06	118.16	114.93	115.60	113.09

Source: NCHOD, 2009

Suicide and undetermined injury mortality

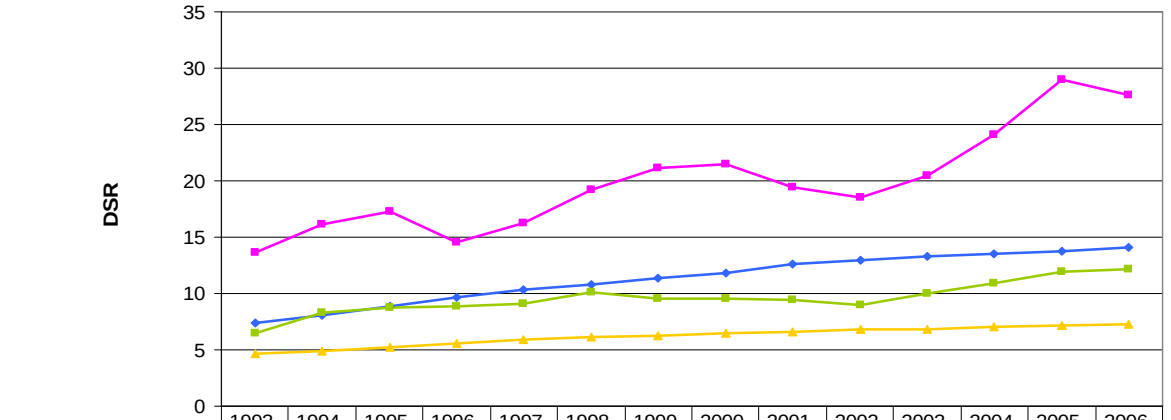
Wirral has a higher suicide/undetermined injury directly standardised rate (DSR) than the North West and England. The rate in Wirral overall has been declining. In 1995/97, the directly standardised mortality rate (all ages) for England was 9.16 compared to a Wirral rate of 13.10 showing a gap of 3.94. In 2006/08, the gap had widened to 4.49 (England; 7.76, Wirral; 12.25).

Digestive Disease

Digestive disease refers to diseases of the digestive system, including the gastrointestinal tract, pancreas and liver (including cirrhosis). Alcohol consumption is highly correlated with premature mortality from digestive disease.

Figure 6 shows the trends in all age mortality (directly standardised rate (DSR) per 100,000) from chronic liver disease in England and Wirral between 1993 and 2008 for males and females.

Figure 6: All age mortality rate (DSR per 100,000) from chronic liver disease (including cirrhosis) in England & Wirral, by sex: 1993–2008



	1993-1995	1994-1996	1995-1997	1996-1998	1997-1999	1998-2000	1999-2001	2000-2002	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008
England (males)	7.36	8.06	8.83	9.62	10.37	10.83	11.31	11.8	12.64	13.01	13.35	13.55	13.79	14.06
Wirral (males)	13.61	16.16	17.31	14.51	16.2	19.19	21.15	21.52	19.47	18.48	20.46	24.07	28.98	27.66
England (females)	4.63	4.91	5.26	5.56	5.88	6.09	6.28	6.43	6.6	6.79	6.86	7.01	7.13	7.26
Wirral (females)	6.51	8.35	8.77	8.88	9.14	10.08	9.55	9.53	9.38	8.94	10	10.89	11.94	12.18

Source: NCHOD, 2009

Overall, death rates from chronic liver diseases have gradually increased in both England and Wirral since 1993-95 but the rate of increase is much more pronounced in Wirral. Mortality from chronic liver disease is higher amongst males than females in both Wirral and England.

The rise in mortality from liver disease and other digestive disorders is caused mainly by alcohol. It is a significant contributor to the failure to meet the target for a reduction in the life expectancy gap locally.

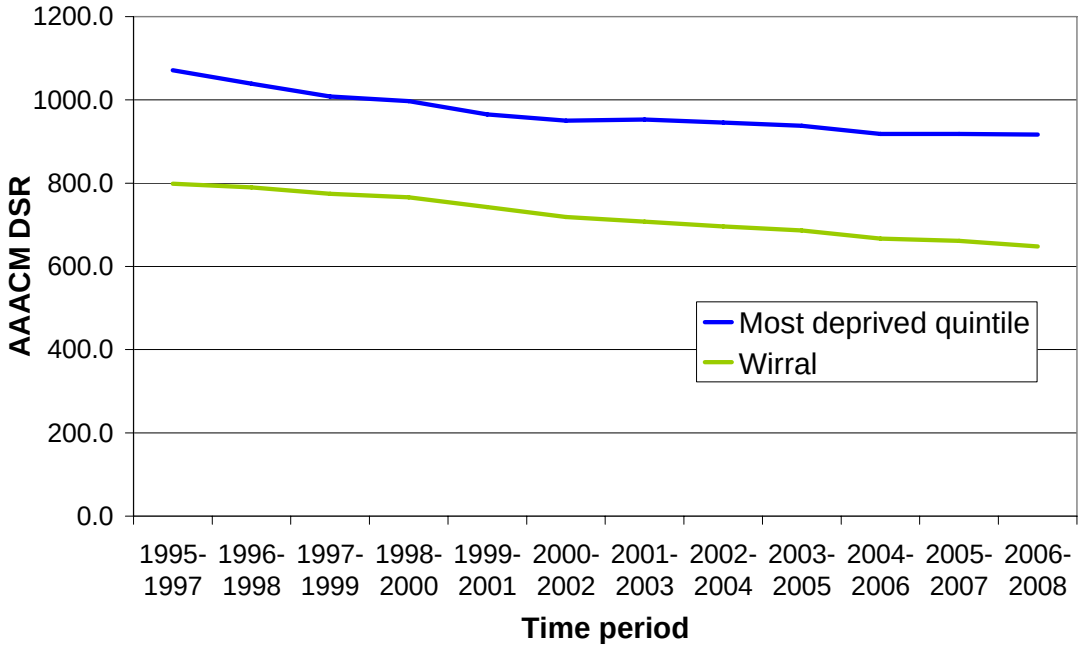
3.2 Health outcome 2. Target timescale 2013

This target is set to achieve a reduction in health inequalities within Wirral by improving the health of people living in the most deprived areas at a faster rate than for the rest of Wirral. This local target was set in the NHS Wirral Strategic Plan as follows:

- A 7% reduction in the AAACM gap for males and females living in the most deprived areas of Wirral by 2013.

This uses the most deprived 20% areas (or most deprived quintile) nationally based on the Index of Multiple Deprivation (IMD) 2007. These areas actually make up 32% of the total Wirral population. The baseline year of this target is 2004-06. Figure 7 shows the trend in all age all cause mortality rates for persons in Wirral and the areas of Wirral in the most deprived quintile. Both have shown a downward trend over the time shown.

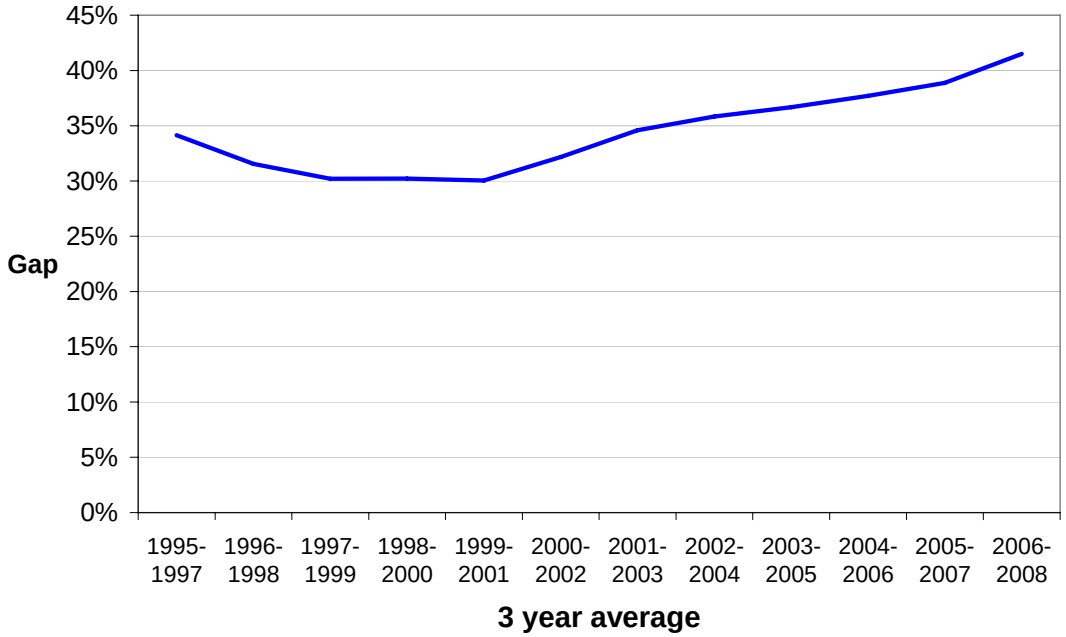
Figure 7. All age, all cause mortality rates in Wirral and most deprived areas, 1995-97 to 2006-08 (3 years pooled time periods).



Source: Calculated from ONS Public Health Mortality Files.

The relative gap in mortality rates between Wirral and the most deprived areas has got wider since 2000. This is shown in Figure 8. The gap is monitored monthly using monthly death files, and as of February 2010 the rolling gap was 41.6%.

Figure 8. Trend in the relative gap in all age, all cause mortality rates in Wirral and most deprived areas, 1995-97 to 2006-08 (3 years pooled time periods).



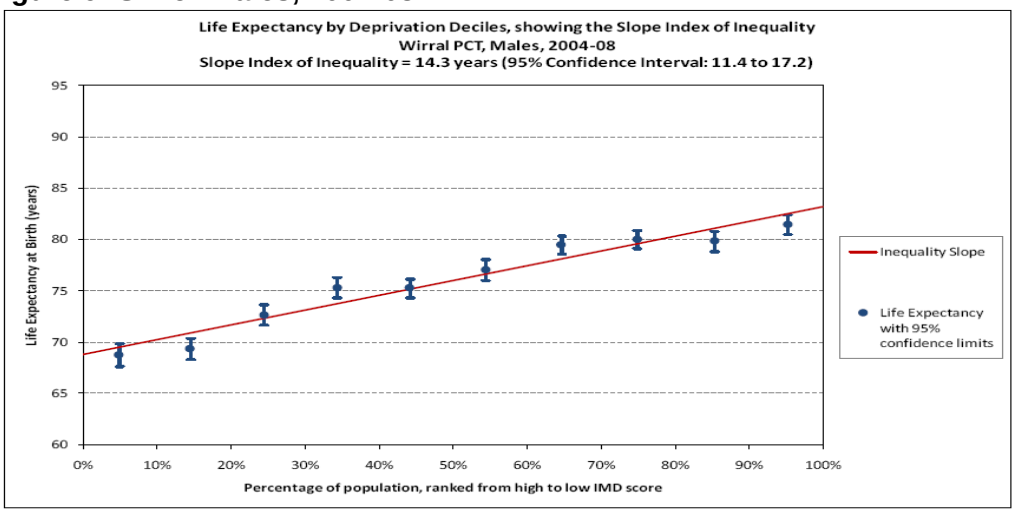
Source: Calculated from ONS Public Health Mortality Files.

The Slope Index of Inequalities (SII)

There is a new indicator that was devised in 2009, the Slope Index of Inequalities (SII). It measures the slope in life expectancy for males and females between the most and least deprived LSOAs, split into tenths (deciles) by deprivation score based on the IMD 2007. 'Slope' refers to the gradient of the line of best fit through the ten deciles of deprivation, so the steeper the gradient, the higher the SII score, and the wider the inequalities in life expectancy are. The SII is not the same as the difference between the maximum and minimum life expectancy by decile in a PCT, because the gradient is affected by all ten points on the line. The SII indicator is based on five years aggregate data. Using five years is necessary to ensure that the numbers of deaths are enough to calculate the SII robustly, and to ensure that there will not be large fluctuations from year to year.

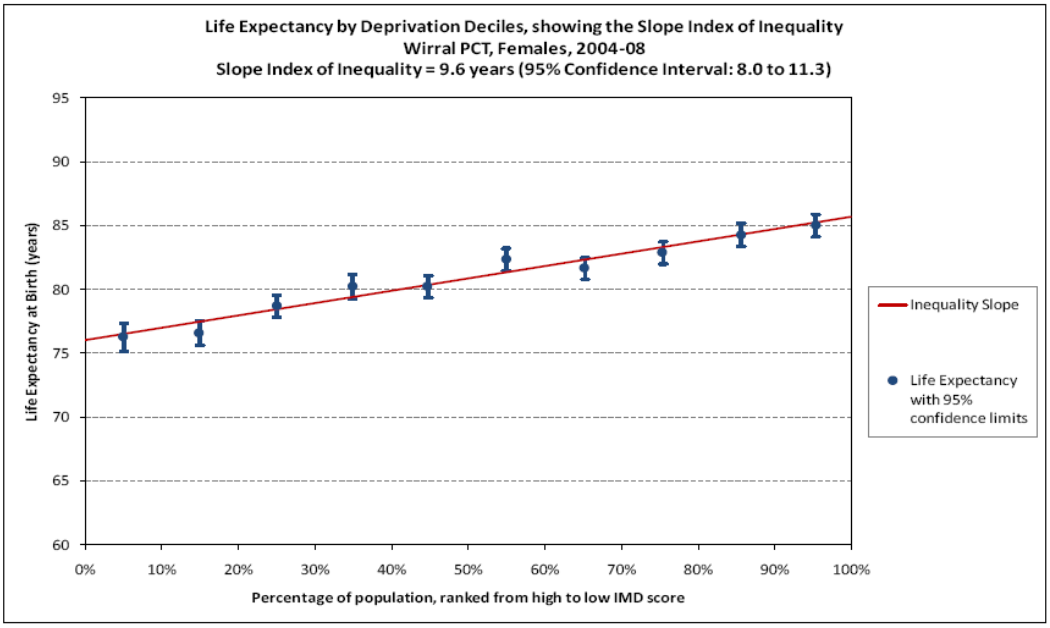
Using 2004-08 data, the SII for males is 14.3 years and Wirral is ranked 5th worst out of 152 PCTs. The SII for females is 9.6 years and Wirral is ranked 9th worst.

Figure 9: SII for males, 2004-08



Source: APHO (Association of Public Health Observatories) 2009

Figure 10. SII for females, 2004-08



Source: APHO (Association of Public Health Observatories) 2009

Using data from 2001 to 2008, it can be seen in table 3, that for males, the SII has increased year on year. For females, there has also been a smaller but increasing trend although in the last time period there was 1% reduction.

Table 3: SII, Males and females to 2004-08.

Actual/Target	Time period	Males	Females
Actual	2001-2005	12.9	9.2
Actual	2002-2006	13.5	9.7
Actual	2003-2007	13.9	9.7
Actual	2004-2008	14.3	9.6

Source: Data from APHO (Association of Public Health Observatories) 2009

It has long been acknowledged that Wirral has a very wide spread of deprivation. Districts with a wide range of communities, from very affluent to very deprived, will always tend to have wide inequalities in health outcomes as well, and the SII will reflect these underlying differences.

Table 4 summarises the gap in under 75 mortality rates between Wirral and the most deprived 20% nationally by cause. Between 1997-99 and 2006-08 for all causes except suicide the gap has got wider.

Table 4: Gap in mortality rates by cause, 1997-99 and 2006-08.

Cause	Gap in under 75s mortality rates		% Change in Gap
	1997-1999	2006-2008	
Cardiovascular disease	49	65	33
Cancer	34	36	5
COPD	82	126	53
Chronic liver disease	37	228	521
Suicide & Injury Undetermined Intent	73	34	-54
Accidents	15	105	586
All causes	45	60	34

Figures 11 – 17 show the trend in the mortality rates in Wirral and the most deprived quintile. Of note is that mortality from COPD, liver disease and accidents seems to be getting higher in the most deprived areas. Mortality from chronic liver disease, which is mainly caused by alcohol, is becoming one of the biggest causes of the mortality gap in Wirral.

Figure 11. Trend in Directly Age Standardised Mortality Rates from Cardiovascular disease, Under 75s, Wirral against most deprived quintile, 1997-2008.

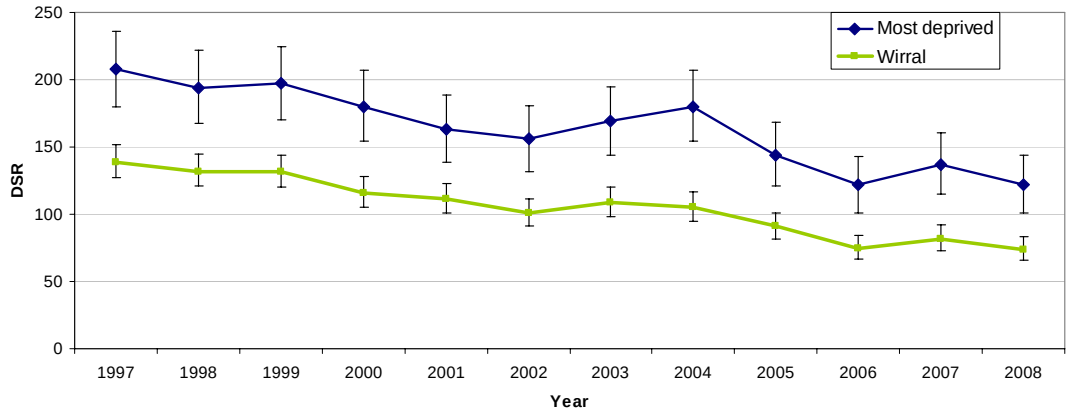


Figure 12. Trend in Directly Age Standardised Mortality Rates from Cancers, Under 75s, Wirral against most deprived quintile, 1997-2008.

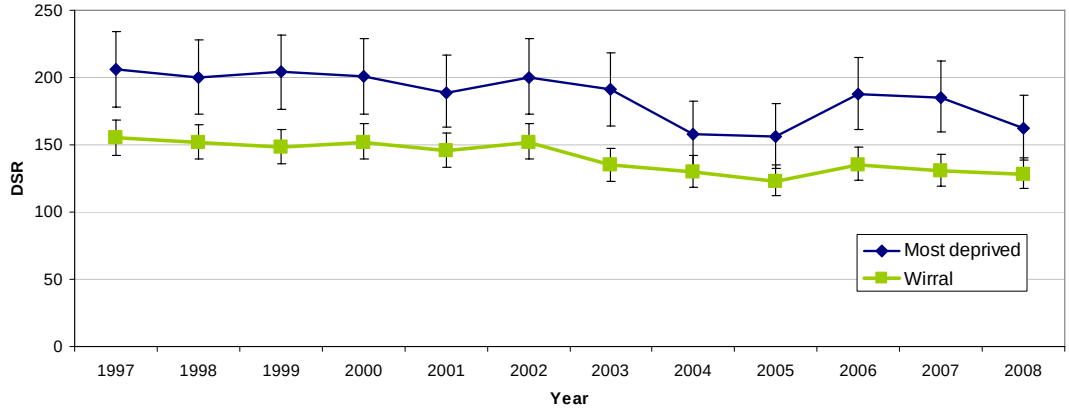


Figure 13. Trend in Directly Age Standardised Mortality Rates from Chronic Obstructive Pulmonary Disease, Under 75s, Wirral against most deprived quintile, 1997-2008.

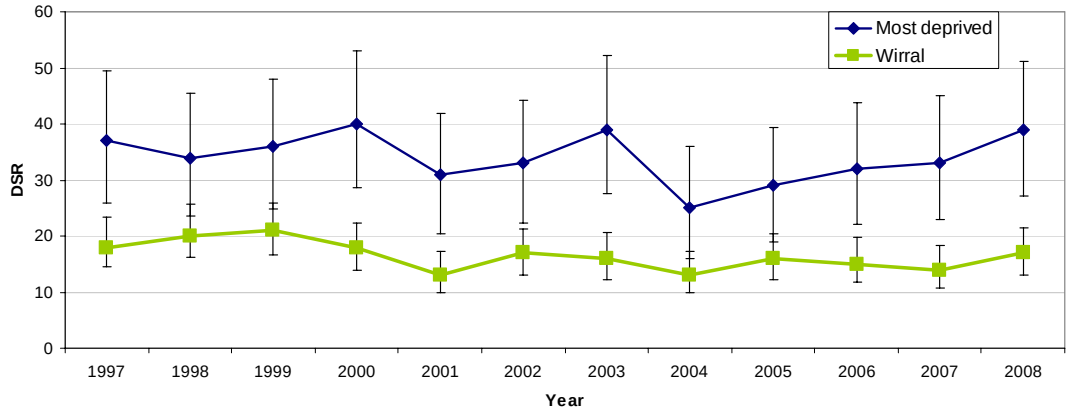


Figure 14. Trend in Directly Age Standardised Mortality Rates from Chronic Liver Disease, Under 75s, Wirral against most deprived quintile, 1997-2008.

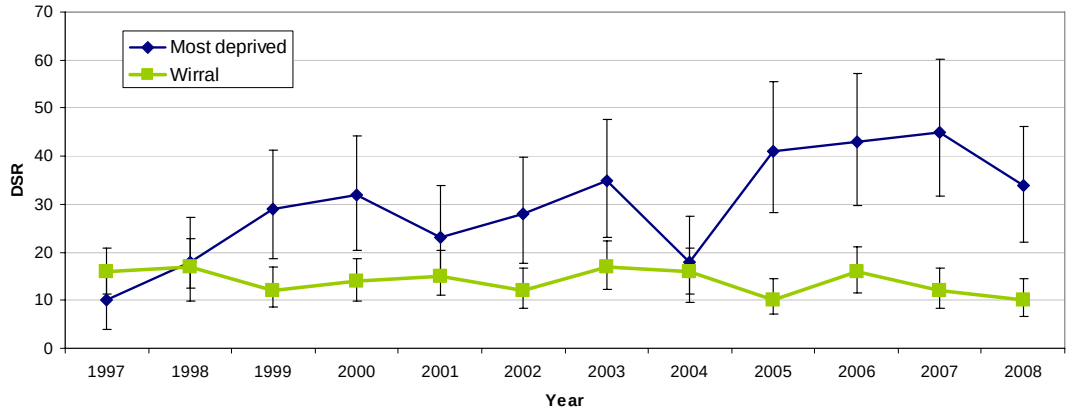


Figure 15. Trend in Directly Age Standardised Mortality Rates from Suicide and Injury Undetermined Intent, Under 75s, Wirral against most deprived quintile, 1997-2008.

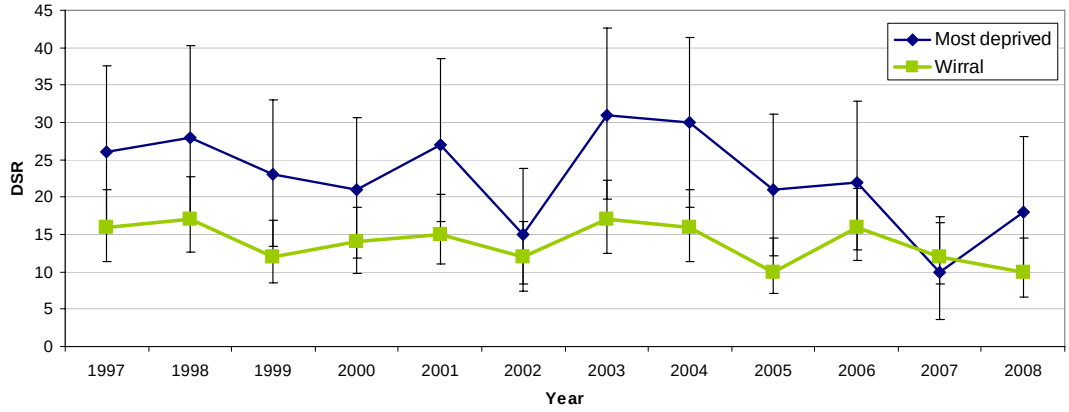
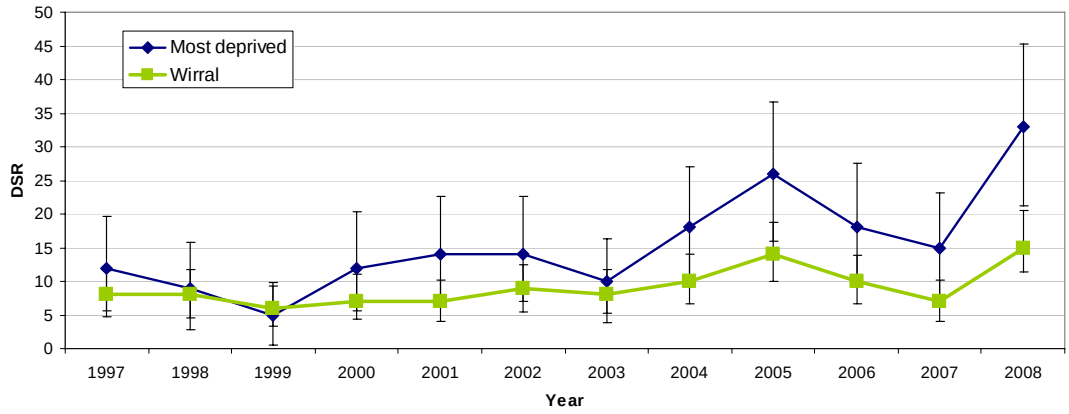


Figure 16. Trend in Directly Age Standardised Mortality Rates from Accidents, Under 75s, Wirral against most deprived quintile, 1997-2008.



3.3 Health outcome 3: Target timescale – 2025

The HIAP aims to achieve improvements in the wider determinants of health that underpin health and well-being in Wirral. It identifies the need to set out measurable targets that will achieve real improvements by 2025. This includes:

- Wirral will improve its index of multiple deprivation position in comparison to other Local Authority Districts by 2020.

There are also three underpinning targets identified in the HIAP that will be discussed in this section:

- 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.

Index of multiple deprivation

The overall Index of Multiple Deprivation (IMD) 2007 is compiled from the following seven domains:

- Income
- Employment
- Health Deprivation and Disability
- Education Skills and Training
- Barriers to Housing and Services
- Crime
- Living Environment

The IMD 2007 is based on data that was gathered in 2005, so it will not be affected by any changes that have happened in Wirral since then. The next IMD is due to be produced in 2010 and consultation has recently been completed on its content and application.

According to the IMD 2007, Wirral is the 60th most deprived of the 354 districts in the country and is therefore in the bottom 20% nationally. This however is a slight improvement on previous data (IMD 2004) when Wirral was placed as the 48th most deprived district. Until the

2010 data are produced, it is not known if Wirral has improved its position since the HIAP was approved.

3.3.1 Underpinning measures

Improvement to Child Poverty

According to the Income Deprivation Affecting Children Index (IDACI) there has been considerable improvement in Wirral on this indicator since 2004. In 2004 there were six areas in the top 100 (most deprived), whilst in 2007 this reduced to three. However, the disparity within Wirral is large with LSOAs being ranked from a 51 to 32,291 (1 is the most deprived and 32,482 is the least deprived of all LSOAs nationally).

The recent (March 2010) Child Poverty Bill places a duty on local administrations to produce a child poverty needs assessment and local action plan in order to contribute to meeting four UK wide targets:

- Relative low income target
- Absolute low income target
- Combined low income and material deprivation target
- Persistent poverty target

The above action will ensure that there is a focus on improving child poverty and that local performance can be tracked.

Improvement to Employment Rate

The Employment domain of the IMD 2007 indicates that Wirral performs poorly on this indicator. It is ranked 8th worst out of 354 districts (bottom 3% nationally). Employment is heavily weighted in the IMD so this is a key contributor for Wirral's poor performance on the IMD overall.

Job Seekers Allowance claimant data, which is the most widely recognised measure of employment, shows that at September 2009 Wirral's unemployment claimant rate was:

- 5.6% (total 10,353), this is higher than both the North West (4.7%) and the England rate (4.2%).

- The claimant count has fluctuated over recent years, reaching a low of 3.1% at the end of November 2007 and peaked at 5.8% in August 2009. The claimant rate is higher amongst males (8.2%) than females (3.0%).

Worklessness is a broader measure of unemployment that also takes into account incapacity benefit claimants, lone parent claimants and other income related benefits. As such it is a more reliable indicator of the economically inactive.

- Levels of worklessness have gradually fallen since August 1999 from a high of 22.3% down to 19% in February 2009 (latest data). This however is higher than both North West (16.4%) and national figures (13.4%).

Improved Educational Attainment

Educational attainment in Wirral has been improving since 2003 and compares favourably with England. Key stage data however, shows inequalities between districts. Tables 5 and 6 demonstrate this at key stages two and four.

Table 5: Key Stage Two 2007 % Level 4+ in both English and Maths by school district and area

	2008	
	Number of pupils	**%L4+ English and Maths**
Wirral	3691	75.0
Birkenhead District	1041	68.9
Bidston & St James/Claughton	364	65.4
Prenton/Oxton	294	84.0
Birkenhead and Tranmere/Rock Ferry	383	60.6
Wallasey District	1058	73.8
Liscard/Seacombe	390	67.2
New Brighton & Wallasey	346	77.5
Leasowe Moreton East & West/Saughall Massie	322	78.0
South Wirral District	681	75.6
Clatterbridge & Bebington	342	86.3
Bromborough & Eastham	339	64.9
West Wirral District	882	83.0
Pensby/Thingwall/Heswall	254	85.0
Hoylake/Meols/West Kirby/Thurstaston	232	90.9
Greasby/Frankby/Irby/Upton	396	77.0

There are significant disparities in attainment between areas of the borough at key stage two, with children in the Birkenhead district achieving 60.6% Level 4+ in both English and Maths compared to 83% in West Wirral, a gap of 22.4%. These disparities are also evident at key stage 4.

Table 6: 2007 KS4 performance data by district and area

	2008			
District/Area	**Number of Pupils**	**% 5+ A* - C**	**% 5+ A* - C inc EM**	**% 5+ A* - G**
National		65.3	47.6	91.6
Wirral All Pupils		65.8	50.2	93.9
Birkenhead District	1128	57.0	38.2	90.3
Bidston & St James/Claughton	423	54.6	36.6	88.7
Prenton/Oxton	298	73.2	56.4	96.6
Birkenhead and Tranmere/Rock Ferry	407	47.7	26.5	87.5
Wallasey District	1221	58.4	41.9	92.7
Liscard/Seacombe	421	49.6	30.6	90.7
New Brighton & Wallasey	402	66.2	52.5	96.0
Leasowe Moreton East & West/Saughall Massie	398	59.8	43.2	91.5
South Wirral District	700	71.0	59.6	95.7
Clatterbridge & Bebington	351	77.2	66.7	96.3
Bromborough & Eastham	349	64.8	52.4	95.1
West Wirral District	990	77.8	65.3	96.5
Pensby/Thingwall/Heswall	285	82.8	74.7	97.2
Hoylake/Meols/West Kirby/Thurstaston	285	83.2	68.8	96.8
Greasby/Frankby/Irby/Upton	420	70.7	56.4	95.7

There is also a significant gap between educational attainment of Children in Care (CiC) and all children. In Wirral in 2008, Key Stage 2 results for Children in Care were below that of all children with a gap of 22% for English and 17% for maths. For key stage 4, the gap is 50% between attainment of CIC and all children in Wirral.

HEALTH INEQUALITIES PLAN
MONITORING REPORT APRIL 2009 – MARCH 2010

REPORT SUMMARY

Introduction

Wirral Health Inequalities Action Plan draws together the evidence based, high impact actions that need to be set in place in order to achieve three targets for Wirral:

- 2010 Target to reduce the life expectancy gap between Wirral and England (three year rolled data to December 2011)
- 2013 Target to reduce internal inequalities in mortality and life expectancy within Wirral
- Impacting on the wider determinants of health to improve health and well-being in groups with the poorest health by 2025

Following advice and support from the National Support Team for health inequalities, priority, high impact actions and targets have been identified and agreed by the relevant partners across the LSP.

Monitoring reports are produced annually to summarise progress on each action. This is the third monitoring report since the plan was agreed by Wirral Strategic Partnership and the first annual report. The report summarises the position at the end of the first year and it is anticipated that this will be used as a basis for discussion on what needs to be done further, to escalate action that is not adequately progressing. When the plan was first produced, it was also anticipated that an annual review of evidence and data would take place in order to inform and agree additional actions to be added to the plan to meet the longer term target.

The Health & Wellbeing Partnership Coordination Group is the accountable theme group for leading the implementation of the plan.

Performance progress

The report of 2009 - 2010 includes progress on 70 actions under five strategic priorities. Designated leads are agreed for each action and reports were requested from these two weeks after the end of the reporting quarter. Progress is RAG rated using the following criteria:

RED: Insufficient action currently set in place / target not being met
Amber: Adequate progress / action expected to be achieved (although may be behind target timescale)
Green: Action achieved in full / current action expected to meet target within timescale

Table 1 below, summarises the RAG rated progress.

Table 1: RAG rated progress against all strategic priority actions

	No of targets	**Red**	**Amber**	**Green**	**% rated green**
Priority 1	12	3	5	4	33%
Priority 2	34	1	15	18	53%
Priority 3	11	0	3	8	73%
Priority 4	10	1	5	4	40%
Priority 5	3	0	2	1	33%
Total	70	**5 (7%)**	**30 (43%)**	**35 (50%)**	

All actions in the HIAP have a designated lead agency - either NHS Wirral or Local Authority. The leads are supported by partners across a range of organisations. Table 2 shows the progress being made by the lead agencies in achieving the strategic priority actions.

Table 2: Progress made by the lead organisations to achieve strategic priority actions

		Red	**Amber**	**Green**
Local Authority	N^{o}	2	5	3
	%	20%	50%	30%
NHS Wirral	N^{o}	3	25	32
	%	5%	42%	53%
Total	N^{o}	5	30	35
	%	7%	43%	50%

Each of the actions in the HIAP will impact on health inequalities although some will take longer than others to contribute to health outcomes. Table 3 shows the RAG rating for the actions that are set to achieve each of the three health outcomes (note that the timescale for achieving health impact from the actions relates to the first outcome they will impact on. For example, actions set to

contribute to outcome one (short term) will also contribute to outcome two and three). Table 3 shows that to date, only 53% of actions set to contribute to achieving the national life expectancy target by the end of next year are green.

Table 3: Progress made against actions to achieve each health outcomes

	Red	Amber	Green
Outcome 1 (2011)	2 (6%)	14 (41%)	18 (53%)
Outcome 2 (2013)	0 (0%)	10 (45%)	12 (55%)
Outcome 3 (2025)	3 (21%)	6 (43%)	5 (36%)

Green – Actions that are on track

50% of actions are now completed (green) or on track to be completed (although some require further monitoring to demonstrate they maintain achievement). These include:

- Actions to embed health impact assessment across Wirral Strategic Partnership policy and planning
- Reducing illegal availability of tobacco and increase access to stop smoking programmes
- Completion of BME health needs assessment
- Review and support to GP practices to achieve maximum performance on primary prevention of main causes of premature mortality including cardiovascular disease (CVD)
- Actions to reduce alcohol misuse
- Implementation of Health Action Area programmes
- Actions to contribute to reduced teenage conceptions and child obesity
- Provision of health equity audit and data to support reduction in premature mortality from CVD and cancers.
- A programme of social marketing to support reduced health inequalities

Amber – actions that require further focus

46% of actions are in progress and require further focus to be fully achieved. These include:

- Excess winter deaths – due to flu pandemic, progress was delayed. A data report has been completed and a steering group established which will ensure that people most at risk in winter 2010 are identified and case management is in place
- Fit for purpose BME data collection in services – although some progress is being made, consistent data sets need to be included in contracts to ensure BME equity of access can be monitored

- Impact – several actions relate to measuring impact on health inequalities (eg enhanced services, exception reporting and primary care training). Review and evaluation has taken place showing that cost effective, quality services have been developed. However, without further evaluation, as these are population wide programmes, it is not known if the impact on health inequalities is positive or negative
- Health equity audit – recommendations from cancer and CVD equity audits need to be developed into action plans
- Alcohol identification and treatment pathways are now in place and require further work to ensure they are fully implemented and utilised
- Involvement of 3rd sector in tackling health inequalities –structures for the new Wirral 3rd Sector Assembly are now agreed and will support this action
- 16-18 year olds not in education, training and employment, child obesity, child accident prevention and children killed or seriously injured in road traffic accidents is progressing but further planning is required in order to improve performance
- Joint intelligence requires further development and co-ordination in order to enhance programmes

Red actions that require review by lead agency

Many of the actions that were red in 2009 have become amber or green between January and March 2010. The five remaining red actions are as follows:

- 1.3 action B - Number of households assisted with energy efficiency measures – the number of households assisted has decreased due to changes in availability of Government grants. Consideration should be given to the impact this will have on inequalities and if alternative arrangements can be made
- 1.6 action A – The proportion of people claiming out of work benefits has risen and continues to be affected by the recession
- 1.6 action B – Programmes are in place to provide health improvement support to people claiming incapacity benefits but numbers into employment are low and require monitoring to judge impact on reducing the number of claims
- 2.9 relates to revascularisation equity of access and rate of procedure. Revascularisation rates are being benchmarked and when available, will be used to assess if Wirral are in the top decile for performance
- 4.4 - The proportion of women continuing to smoke throughout pregnancy has risen over the last 12 months despite increased numbers of women successfully quitting with NHS stop smoking services.

Recommendations

The following recommendations arise from this report:

- The Health and Well-being Partnership Co-ordination Group should consider what support (resource, information, leadership etc) needs to be set in place in order for amber and red actions to become green and what the timescale will be for achieving this. The actions and timescales in the plan should be amended to reflect any changes agreed
- Plans to address health outcome one, should be the initial focus of discussion to ensure that the 41% of amber and 6% of red actions are resolved. For those actions that are already green, consideration should be given to any 'stretch' that can be achieved to impact further on next years life expectancy target
- Networks that are in place to support the 3rd sector should be utilised to engage a larger range of organisations and groups in determining future actions to reduce health inequalities for all three of the health outcomes in the HIAP
- The report; *Fair Society, Healthy Lives; a Strategic Review of Health Inequalities in England post 2010* should be used as a basis for reviewing and agreeing targets and actions to achieve longer term reduced health inequalities.

HEALTH INEQUALITIES ACTION PLAN
ANNUAL REPORT
2009-2010

Note: The comments in italic relate to suggested additional work that needs to be completed in order that the RAG rating becomes green

Strategic Priority 1: Address the underlying determinants of health

1.1 Ensure that development plans for Wirral Waters maximise positive impact on health inequalities		
LEAD: David Ball – Head of Housing & Regeneration Rob Beresford – Head of Regulation **ACTION A:** Complete a health impact assessment on Wirral Waters Development Plan including recommendations for action		**Action progressing** A high level desktop HIA was produced by the applicant for the WW development. Comments were submitted by the Director of Public Health and a response from the applicant is pending.
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		
LEAD: Rob Beresford – Head of Regulation **ACTION A:** Review and re-launch the Smoke Free Wirral Action Plan		**Action completed** Smoke Free Wirral Action Plan is reviewed and being implemented. Trading Standards Officers monitor sale of tobacco to children and work with HMRC to seize illegally imported tobacco products not complying with UK health warnings
1.3 Ensure that vulnerable individuals are able to live in homes that are warm		
LEAD: Ed Kingsley – Principal Officer Home Energy **ACTION A:** Review the Affordable Warmth Strategy and ensure there is an effective partnership group to lead an associated action plan		**Action in progress** The Affordable Warmth Strategy was reviewed in 2008 and is due to be reviewed again in September 2010. A new steering group met on 4th February 2010 to progress with the review; terms of reference for the group have been written and membership currently consists of officers from Wirral Council, NHS Wirral, Merseyside Fire & Rescue Service and third sector organisations. *This is a key action to impact on excess winter deaths contributing to achievement of the 2010 life expectancy target. It is not clear if the planned review and any recommendations will be within the timescale to impact on the target*

LEAD: Ed Kingsley – Principal Officer Home Energy **ACTION B:** Increase the number of vulnerable households assisted with at least one main energy efficiency measure under Warm Front (LAA – local target)		**Action in progress but target not expecting to be achieved** The number of households assisted with Warm Front: 2007-08 – 2648 2008-09 – 2717 (2.6% increase) 2009-10 – 2003 (26.3% decrease) The reason for the decrease in 2009-10 was that on 23 April 2009, the Government announced its intention to increase the maximum grant available to households under Warm Front by about 30% for gas heated properties and 50% for oil heated properties, without increasing the overall budget. In October 2009, demand for grants began to outstrip supply as, in the Government's own words, "The increase in grant maxima has led to an increase in the average spend per household and fewer households requested to make a contribution. This will lead to fewer households being helped within the available budget". In November 2009, the Warm Front scheme manager, Eaga, increased waiting times for grant applications to control the number of grants issued. Unless the Government increase spending on Warm Front in 2010-11, there is likely to be a further decrease in households assisted. *Number of households supported is likely to further decrease. Review needs to take account of the impact on health inequalities*
1.4 Ensure key agencies and Wirral Strategic Partnership have sufficient information to lead action to address excess winter deaths		
LEAD: Tony Kinsella – Head of Performance & Intelligence **ACTION A:** Set in place the mechanism to collate and report on excess winter deaths including number and locality		**Action in progress** Systems are in place for the collation of data and a report has been produced, However, further work needs to be done to make data available on a regular basis and by locality *Establish a reporting system for winter 2009/10*
1.5 Improve Data collection and intelligence on black and racial minority populations in Wirral		
LEAD: Julie Graham – Acting Joint Head of Health & Wellbeing (Healthy Communities) **ACTION A:** Carry out a health and wellbeing needs assessment amongst the BRM population		**Action completed** BME Health and Well-being Needs Assessment complete and included as part of the JSNA to ensure accessibility.

LEAD: Jackie Collier / Tony Kinsella – Head of Performance & Intelligence **ACTION B:** Establish fit for purpose data collection methods within key services to assess access by BRM groups		**Action in progress** More robust contract clauses relating to collection of BME data have been included in the March 2010 provider service, acute, oncology and CWP contracts. An action plan is to be developed for supporting services to develop data collection and reporting on BME status. The next step will be agreeing actions for the Single Equality Scheme to assist provider services in improving the accuracy and level of collection, and developing a usable reporting method. *A review of data being collected as a result of improved contract specifications to see if it is appropriate and accessible for equity analysis by services and performance and intelligence team*
1.6 Reduce economic inactivity		
LEAD: Kevin Adderley – Head of Strategic Development **ACTION A:** Reduce the proportion of working age people claiming out of work benefits (LAA / NI153)		**Action in progress** Action A is heavily scrutinised and reported through existing channels and data will be available by due date. Interim data indicates an increase in NI 153 – from 36.7% in May 09 to 37.5% in August 09 (latest data). The impact of the recession in increasing economic inactivity is being closely monitored, and a number of very successful interventions have been developed. *Action is affected by recession and continues to be monitored*
LEAD: Neil Perris – Head of Public Health Provider Services **ACTION B:** Reduce the number of people claiming incapacity benefits		**Action in progress** Two key programmes work to reduce IB claimants from which outcomes include: 1st year of WW4H programme, operational for 9mths: 83 leavers: 22 employed & 61 unemployed. 21 employed leavers who were at risk of moving to I.B. retained in employment, 1 became self-employed. 56 leavers were referred to other health & employability partners, eg Health Action Area's and Working Links. 61 leavers unemployed: 8 were DNA's. Of the 53 - 38 referred to other support , advice , guidance and 5 claimants in to employment *Whilst programmes are successfully supporting people who are at risk of, or already on incapacity benefits, numbers are currently not sufficient to reduce total number of claimants.*

1.7 Support the development and maintenance of skills and independence in vulnerable adults		
LEAD: John Webb – Director of Adult Social Services Maura Noone – Head of Communities and Wellbeing (DASS) **ACTION A:** Increase the number of people supported to live independently through social services – all adults (LAA local target)		**Action being met (ongoing)** The performance outturn for NI 136 "People supported to live independently through social services (all adults)" (local LAA indicator) is 2195.65. Target was 2230.05 (1.54% difference). Individuals are also supported to remain independent through Home Assessment Reablement Team and through POPIN which are not included within the definition of NI 136. *Performance is slightly below target*
1.8 Maximise the Health & Wellbeing impact of new programmes and policy changes on potential vulnerable and excluded groups		
LEAD: Carolyn Curr – Head of Policy **ACTION A:** Steps are in place to carry out equality and diversity impact assessment on all new programmes and policies		**Progress being made** The LSP does not currently have a shared template for equality impact assessments. However, the development of a Wirral Equalities Charter will enable this to happen. An extensive Equality Impact Assessment programme in place monitored by Corporate Equality Group. *Processes being developed but still to be implemented*
LEAD: Carolyn Curr – Head of Policy **ACTION B:** An approach to Health Impact Assessment (HIA) being developed by the Health and Well-Being group, in collaboration with IMPACT		**Action has been met and will facilitate ongoing development of HIA** IMPACT has been commissioned to provide training for partners and second staff to the partnership to develop HIA skills and capacity. The secondee is appointed and an Induction programme and work programme being developed. Planned start date April 2010

Strategic Priority 2: Improve access to high quality public services for people with poor health & wellbeing

2.1 Improved QOF performance in areas that are major contributors to reduced mortality		
LEAD: Tony Kinsella – Head of Performance & Intelligence **ACTION A:** Review practice QOF scores in all high impact areas and identify low scoring practices (eg CHD 5,6,7,9)		**Action complete - process in place and ongoing** A review of QOF scores for high impact indicators (eg CHD, COPD) has been carried out by localities. QOF scores are discussed with each practice during QOF visit and an action plan for driving up performance is produced as a result, where this is required. Records are collated of lower scoring practices and subsequent performance compared to ensure it is improved. It is acknowledged across the Localities that measuring QOF achievement may not be the most useful analysis as achievement is near 100% each year. For this reason the balanced scorecard was developed in which practices' achievement without exception reporting is stated. Furthermore, practices' achievement in relation to NICE targets rather than QOF is more accurate in highlighting practices where there are difficulties in particular clinical areas.
LEAD: Heads of localities Paul Edwards - Birkenhead Lorna Quigley – Bebington & West Wirral Andrew Cooper – Wallasey **ACTION B:** Support low scoring practices to produce a recovery plan to achieve maximum QOF points in high impact areas		**Action complete - process in place and ongoing** Practice achievement of high impact indicators has been reviewed and compared with latest achievement for 09/10. Practices have been given until mid-April 2010 to validate their balanced scorecard data, and from this point graphs will be sent to practices highlighting their distance in these two areas from the PCT average. Localities will be made aware of the practices failing to meet PCT average so that an action plan may be set up to support the practice.
2.2 Use financial incentives and local payment schemes to maximise impact on life expectancy and health inequalities		
LEAD: Cathy Gritzner – Director of Health Systems Management **ACTION A:** Review PCT and LHD local enhanced services against performance, health impact and value for money		**Action partially completed** Local enhanced services have been reviewed although health impact was not included. *Review LES against performance, health impact and value for money*

LEAD: Cathy Gritzner – Director of Health Systems Management **ACTION B:** Review exception policy for practices and impact on health inequalities		**Action partially completed** Exception procedure in place. Level of exceptions at practice level are periodically reviewed. However, this does not take account of impact on health inequalities because the data are not broken down into equalities or disadvantaged groups *Consider how current exception policy could impact on health inequalities and if there is a need for further review*
LEAD: Cathy Gritzner – Director of Health Systems Management **ACTION C:** Review the support, resources and development available to practices to reduce exception reporting, achieve higher QOF and LES activity in high impact areas		**Action is progressing** The support to practices to reduce exception reporting and achieve higher LES and QOF activity is regularly reviewed by localities. Several methods of support have been set in place and led to high levels of achievement overall.
2.3 Ensure quality training is available to practice staff and that records demonstrate high levels of completion		
LEAD: Abhi Mantgani – Medical Director Heads of localities Paul Edwards - Birkenhead Lorna Quigley – Bebington & West Wirral Andrew Cooper – Wallasey **ACTION A:** Review the training needs of practice staff to achieve performance improvements in the health inequalities high impact areas		**Action is progressing** Robust processes are in place for assessing needs and providing and evaluating quality training for practice staff. This has covered some of the high impact areas such as CVD and COPD. Further needs assessment would be advantageous to ensure health inequalities issues are included. Reports from localities include: **Overall:** Six Protected Learning Time events per year, topics chosen by the Training forum based on current issues pertaining to the Locality demographic eg diabetes, anti-biotic prescribing, and also according to PCT recommendation, i.e Safeguarding. Professional Development Nurses implement a rolling programme of training based on needs according to the demographics of the area and of QOF. This is reviewed continually. **Bebington and West Wirral:** Training is agreed by the Locality Training Forum, practices carry out training needs assessment internally, a training plan is compiled and training commissioned. **Birkenhead:** Training budget devolved to practices, which carry out training needs assessment internally and make investment accordingly. Training events are held annually as per requirements of local enhanced services: CVD, CKD and Diabetes. **Wallasey:**

		Training budget stays as one in the Locality. Practices have a system for requesting training which is then discussed at a monthly Training Forum. The training forum has a GP Member, Nurse Member, Practice Managers and PCT Members. Practice based training is booked in bulk sessions for practices to access at their convenience. Internal Protected Learning times also occur quarterly and it is the practices' responsibility to organise training on these days, these are monitored by requesting evidence of training from practices. *Consider the health inequalities high impact areas in order to meet 2010 target and 2013 local target and review recent training and future plans to see if gaps remain requiring further training or development*
LEAD: Abhi Mantgani – Medical Director Heads of localities Paul Edwards - Birkenhead Lorna Quigley – Bebington & West Wirral Andrew Cooper – Wallasey **ACTION B:** Establish systems to maintain and review up to date training records of primary care staff		**Action complete** Localities maintain training records for locality training
LEAD: Abhi Mantgani – Medical Director Heads of localities Paul Edwards - Birkenhead Lorna Quigley – Bebington & West Wirral Andrew Cooper – Wallasey **ACTION C:** Agree standards for training and development linked to quality payment scheme		**Action complete** Training and development requirements are clearly outlined within each enhanced service. Training is not lined to QPS as localities co-ordinate training.

2.4 Identify inequalities in the prevention, diagnosis and treatment of cancer and CVD		
LEAD: Tony Kinsella – Head of Performance & Intelligence **ACTION A:** Complete a cancer equity audit review and produce an improvement action plan to implement recommendations		**Action in progress** Cancer equity audit has been completed as a first draft and areas highlighted for action are being planned, including producing an early intervention and prevention plan. *Produce recommendations and an action plan for implementation*
LEAD: Teresa Owen – Public Health Consultant **ACTION B:** Complete a CVD equity audit review and produce an improvement action plan to implement recommendations		**Action in progress** CVD equity audit has been completed as a first draft and areas highlighted for action are being planned. *Produce recommendations and an action plan for implementation*
2.5 Ensure patients with high risk of CVD and not in contact with primary care are supported to maximise their risk reduction		
LEAD: Abhi Mantgani – Medical Director **ACTION A:** Establish interface between Health Action Areas and Primary Care to ensure data and patients are supported to move between clinical and lifestyle programmes		**Action completed** Core offer for practices has been agreed. Medical Directors have written to all practices to encourage them to engage fully with Health Action Area Programme. Health Action Area teams work in local communities and attempt to engage with patients at high risk of CVD. Patients are supported to make positive lifestyle changes via personalised behaviour change action plans. Health Trainers work alongside Health works as part of the Vascular Screening Programme. All practices have designated HAA leads. Health Trainers running support sessions from local practices. Pathways are in place to allow Primary Care staff to refer into and signpost patients to access Health Trainer support.
2.6 Ensure that structural constraints are removed if they prevent services from collaborating to deliver improved health and wellbeing to the population		
LEAD: Tina Long – Director of Strategic Partnerships **ACTION A:** Review the partner alignment and structures for		**Action progressing** Structural constraints have been identified and significant progress made in the development of integrated working between health and social care. Locality Boards are representative of health and social care. Partners have agreed the need to align localities in relation to CYP services. How this is managed amidst differing catchment and figuration of core services such as practices and

delivering services to children, young people and adults and make recommendations for maximising resources, quality and equity of access		schools is being considered. Front line services continue to co-locate and core induction training is being rolled out to the whole CYP workforce
2.7 Patients treated for angina are supported to adhere to their care plan		
LEAD: Frieda Rimmer – Head of Heart Centres **ACTION A:** Protocols for the referral of patients with angina for exercise tolerance testing are reviewed and procedures set in place to ensure minimum standards are achieved and adherence to care plans reviewed		**Action completed** Exercise Tolerance Testing (ETT) care pathway agreed by all Intermediate clinic stakeholders and used for direct access ETT patients. Continuous clinical audit in place on positive ETT requiring secondary care intervention. Appropriate patients referred onto the cardiac rehabilitation programme.
2.8 Increase support available for patients with CVD to adhere to medication therapy		
LEAD: Julia Simms – Head of Medicines Management **ACTION A:** Review the support available for patients on medication to reduce CVD risk and make recommendations for improving support.		**Action complete** 75% of pharmacies will now accept triaged referrals from the PCT for Medicines Use review (MUR) and this is supporting PCT capacity for medication review. CVD agreed as the target area for MUR in 2010/11. The training package and materials will be developed in Q1 2010/11. The package will include strategies to promote uptake of MURs to CVD patients. Support available has been reviewed and includes:- (i)QoF target for GP practices- *'a medication review is recorded in the notes in the preceding 15 months for all patients being prescribed 4 or more repeat medicines. Standard 80%.'* Practice nurse clinics also focus on CVD and other chronic disease patients. (ii)PCT medication review service and criteria for referral include non compliance. GPs, provider services staff, hospital pharmacists and a number of social care teams can refer patients with compliance problems. This applies to all conditions, not just CVD. It is a specialised targeted service because staffing would not support review of all Wirral patients. Also developed onward referral of the above to the community pharmacy Medicines Use Review (MUR) service (part of the national contract). Pharmacies select patients, or patients can request a MUR but PCTs can also recommend target groups of patients (pharmacies are not required in the

		contract to adopt PCT recommendations). Onward triage of appropriate referrals from the PCT medication review service to MURs is in a development phase and it is hoped this will build additional capacity to increase the number of medication reviews available to patients- considering there are only 6WTE PCT pharmacists for 61 practices and they have much wider roles than medication review.
2.9 Increase revascularisation rates		
LEAD: Tony Kinsella – Head of Performance & Intelligence **ACTION A:** Benchmark revascularisation rates and set out mechanisms to ensure PCT is in top 10% nationally (whilst reducing any inequity of access)		**Plans in place to complete action** Revascularization benchmarking data, Part of Cardiac review going to PEC in April 2010. *Complete benchmarking, identify current position and set out plans to achieve top 10% position*
2.10 A care pathway is in place and being adhered to for primary angioplasty		
LEAD: Abhi Mantgani – Medical Director **ACTION A:** Consult with relevant clinical and patient groups to agree and launch a map of medicine care pathway for primary angioplasty		**Partially completed, clarity required** A map of medicine pathway for angioplasty is in place but needs to be reviewed to assess if it covers primary angioplasty or if, in fact, it should. *Complete desk top review to determine if further work on pathway is required*
2.11 Retention and completion within cardiac rehabilitation programmes is maximised		
LEAD: Frieda Rimmer – Head of Heart Centres **ACTION A:** 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.		**Action completed** National Team were contacted, as we are not linked into the National Data set, prior data is not available. Audit competed from October to December on patient attendance rates from all postcodes of the Wirral.

LEAD: Frieda Rimmer – Head of Heart Centres **ACTION B:** Set in place an action plan to improve adherence and increase equity of access		**Action completed** Audit results analysed and action plan produced and implemented
2.12 Prescribing recommendations for Champix and other smoking cessation treatments are reviewed.		
LEAD: Julia Simms – Head of Medicines Management **ACTION A:** Current prescribing guidance is reviewed regarding first and second line treatment options.		**Action on course for completion** Detailed evidence review, costing analysis and benchmarking compared to practice in other NW PCTs completed. Guideline review discussion planned. *Complete discussion and implement any recommendations*
2.13 Improve stop smoking success rates from 35% to 50%		
LEAD: Neil Perris – Head of Public Health Provider Services **ACTION A:** Review support available to intermediate stop smoking services and set in place action to improve follow up and ongoing engagement of smokers to improve success rates		**Action complete** Specialist Advisors allocated clusters of Intermediates to support with their stop smoking activity. Success rate within Intermediate Services has now increased to 47%. In 08/09 it was 43%. Specialist Service success rate has remained above the 50% target *Achieve 50% success rates across all intermediate services as well as specialist services*
2.14 Ensure that smokers with high risk co-morbidities are targeted to stop smoking		
LEAD: Kim Ozano – Smoking Programme Manager **ACTION A:** Produce action plan to target high risk smokers with support to quit		**Action complete** Action plan has been produced and is being implemented. Implementation Action Plan has been devised and shared with the Commissioner at the Tobacco Control Meeting on 19/03/10. Links established with key areas in secondary care and Stop Smoking Service. Trust activity reports requested, to be issued monthly. Training needs assessed in key areas. Training dates set. Training packages being developed**.** Resources available for frontline staff.

2.15 Produce an action plan to address excess cancer deaths in Wirral		
LEAD: Dr Murray Freeman – Clinical Cancer Lead **ACTION A:** Conduct a review into excess cancer deaths, particularly for women		**Action completed** An analysis of excess cancer deaths has now been completed for the period 1993-2008. This has been undertaken for the main cancers for men and women –for all cancers. The report is via Standardised Mortality Rates (SMRs) –and provides a useful picture of Wirral in comparison with England, North West and the Industrial hinterlands.
LEAD: Teresa Owen – Public Health Consultant **ACTION B:** Produce a resourced action plan to reduce cancer excess deaths at least in line with statistical neighbours		**Action completed – ongoing monitoring of excess cancer deaths** Using the data from Action A, and other intelligence available from the PHIT and other national sources, and following three meetings of key stakeholders we agreed the priorities and key elements of general action plan. We have agreed to focus on early detection and prevention as our approach to reducing the excess cancer deaths and a Cancer Early Detection and Awareness plan will be developed. This has been discussed and approved at the Cancer Network Group. The timeline for plan development was agreed at the inaugural Cancer Network meeting. This will address excess deaths as outlined – however given the increasing focus on early detection and the work of the MCCN – this is agreed as the appropriate next step and next requirement.
2.16 Services for breast cancer are reviewed and recommendations implemented		
LEAD: Teresa Owen – Public Health Consultant **ACTION A:** Commission a review of breast cancer services and make recommendations for areas of improvement		**Action in progress** PHIT team analysis undertaken (where data available). Because we continue to await data from provider we have split the report into 2. Part 1 review focuses on the burden of disease and is complete and has been presented to PEC. Part 2 underway and awaiting data. Should be finalised by May. *Completion of review and recommendations*
2.17 Identify, support and reduce the risk of excess winter death amongst vulnerable older people		
LEAD: Tina Long – Director of Strategic Partnerships **ACTION A:** Work in partnership to identify people most at risk from seasonal winter death / hospital admission (winter risk list)		**Action in progress** Review of excess winter deaths has been completed. Further work is being completed to determine how the winter risk list should be compiled (identify risk factor). *Complete identification of people at risk*

LEAD: Tina Long – Director of Strategic Partnerships **ACTION B:** 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		**Action in progress** Care plans and key workers are being identified for patients who are repeatedly admitted to hospital. This process will be expanded to include the winter risk list when available. *Complete process and ensure care worker is in place for each person on the at risk list*
LEAD: Tina Long – Director of Strategic Partnerships **ACTION C:** Establish a Winter Planning Group to ensure that partnership plans are in place to manage increased health risk associated with the winter season		**Action completed** Winter planning group is in place and is developing partnership plans to manage excess winter deaths prevention.
2.18 Establish care pathways for alcohol		
LEAD: Mindy Rutherford – Alcohol Programme Manager **ACTION A:** Review, revise and promote care pathways for alcohol		**Action complete** o All alcohol service contracts have been amended for 2010 to introduce an obligation for all services to refresh and publish service pathways on NHS map of medicine. o Budget has been identified to progress RCGP training programme to improve knowledge relating to the management of harmful and dependent drinkers o Service leaflet and staff directory have been produced to promote availability of services. o
2.19 Review of implementation of care pathway		
LEAD: Mindy Rutherford – Alcohol Programme Manager **ACTION A:** 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 groups such as those in criminal justice system)		**Action complete** A baseline audit has been completed and makes quality improvements in respect of pathways for Tier 3 and 4 services. A subgroup will take these forward. Work has commenced on the development of a training resource relating to identification and brief advice. A joint action plan is in place and under review to improve the hospital pathway with support from alcohol engagement workers. Improvements relating to joint alcohol assessments have been made in pathways for homeless people to improve access to resident detoxification and rehabilitation facilities. Redesign proposals are underway to introduce a crisis intervention service to prevent unplanned hospital admissions. Residential assessment pilot has been commissioned to provide up to 72 hour residential assessment service for alcohol users

2.20 Review alcohol interventions to ensure health outcomes from invested resources are maximised		
LEAD: Mindy Rutherford – Alcohol Programme Manager **ACTION A:** Review all existing and planned alcohol interventions and services ensuring there is systematic evaluation of outputs, outcomes and value for money		**Action completed** Round of informal visits completed and SWOT analysis undertaken. Additional capacity agreed to support evaluation plan development. Logic model draft produced.
2.21 Ensure Children and Young People at risk of repeat self harm or alcohol misuse are provided with effective information on alcohol		
LEAD: Mindy Rutherford – Alcohol Programme Manager **ACTION A:** Review protocols for providing information to children and young people following self harm to ensure it routinely includes alcohol brief intervention		**Action in progress** New service commissioned through CAHMs to improve pathways for young people presenting to A&E and hospital as a consequence of alcohol misuse. Progress will be reviewed New Alcohol Prevention programme of work commissioned to address alcohol misuse amongst young people. Projects established from 1st September 2009. An external consultant has been commissioned to develop a guidance document for schools and youth settings on the management of alcohol related incidents. Will complete a draft document for consultation. With a full consultation it is likely to be out to schools and youth settings for September 2010. *Completion of current planned work*
2.22 Identify people on GP registers at risk of chronic ill health due to alcohol		
LEAD: Mindy Rutherford – Alcohol Programme Manager **ACTION A:** Develop a mechanism to identify patients on GP registers that are at risk of chronic ill health due to alcohol		**Action partially complete** 30/61 GP practices are registered as part of the DES to deliver alcohol screening for newly registered patients with two thirds of referrals into Wirral Alcohol Service Dependant Team originating from GPs. *Develop a mechanism for screening patients other than newly registered*
LEAD: Mindy Rutherford – Alcohol Programme Manager **ACTION B:** Implement a mechanism to search, review and sign post to alcohol pathway and follow up, patients at risk		**Action partially complete** 30/61 GP practices are registered as part of the DES to deliver alcohol screening for newly registered patients with two thirds of referrals into Wirral Alcohol Service Dependant Team originating from GPs. *Develop and implement a process for search, review and sign post*

2.23 Ensure that obese people with co-morbidities are provided with interventions that improve their quality of life and reduce premature mortality		
LEAD: Julie Graham – Acting Head of Health & Wellbeing (Healthy Communities) **ACTION A:** Establish comprehensive care pathways for primary and secondary prevention and treatment of obesity		**Action partially complete. Awaiting review of bariatric pathway** Child Obesity – 3 pathways on Map of Medicine Bariatric Pathway (adult) developed meeting next week to discuss review across Cheshire & Merseyside Health & Wellbeing Life Course pathway developed *Complete all pathways*

Strategic Priority 3: Engage communities and individuals, supporting them to improve their health through the health and wellbeing choices they make

3.1 Reduce smoking prevalence by 8,000 smokers per year		
LEAD: Julie Graham – Acting Head of Health & Wellbeing (Healthy Communities) **ACTION A:** 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		**Action complete, ongoing monitoring of target required** The following achievements are estimates for the end of Q4, however complete accurate data for smoking targets will not be available until June end. Stop Smoking Service - **2,410** 4-week quitters Social Marketing Campaign - **500** 4-week quitters (Campaign launch Feb 2010) National, Regional and local marketing – **1,500** less smokers from the 20% most deprived areas in Wirral (identified through smoking prevalence and behaviour survey Oct 2009) **Total = 4,410** The Stop Smoking Social Marketing Campaign "Your Reason Your Way" - over 1,000 smokers registered with the campaign in the first two months. 70% of these were from the 20% most deprived areas in Wirral.
3.2 Work to a shared vision for partnership, third sector and public engagement		
LEAD: Andy Mills – Head of Engagement **ACTION A:** Agree and complete an engagement process with the voluntary sector to identify key actions and programmes that will impact on health inequalities and the outcomes they will achieve against each of the target timescales		**Processes in place to enable action to commence** On 10th March 2010, VCAW had approval from existing members of the VCAW 'Network' to re-structure WVCSN to become the 'Wirral 3rd Sector Assembly'. Wirral 3SA will move toward a new model of empowerment which gives voice for the sector through its members. All Third Sector Organisations are eligible for membership. The above forums will provide a platform to agree key actions *Carry out an engagement process focussed on identifying key actions to impact on health inequalities*
LEAD: Andy Mills – Head of Engagement **ACTION B:** Develop a partnership engagement strategy for the Wirral Strategic Partnership		**Action completed** The cross-borough Comprehensive Engagement Strategy (CES) completed in partnership with LSP and is referenced within NHS Wirral Communications & Engagement Strategy document.

3.3 Identify people not in contact with primary care services and support them to reduce health and wellbeing risk		
LEAD: Julie Graham – Acting Head of Health & Wellbeing (Healthy Communities) **ACTION A:** 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)		**Action progressing** To date 3, 676 Health Checks have been offered and 2081 have been completed within community settings. Plans to utilise the remaining health checks through large scale events are being developed. It is estimated that approximately 3,000 Health checks will be taken up by people in the community by the end of June 2010. This is in addition to health Checks being offered to all 40-74 year olds through GP practices *Complete planned process*
LEAD: Neil Perris – Head of Public Health Provider Services **ACTION B:** 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 alcohol consumption, improved diet and improved mental wellbeing		**Action complete** A Community Programme of activities is now established, focussed in the most deprived areas of Wirral. There is still plenty of scope for expansion and development of the activities available to target those at greatest risk of ill-health. The attendance target for CP activities was 8000. Attendances of the CP between April 2009 – March 2010 = **19,076**
LEAD: Neil Perris – Head of Public Health Provider Services **ACTION C:** Ensure the Health Trainer workforce are linked to practices to support patients at high risk to make lifestyle changes		**Action complete** Links have been established with GP practices within the HAAs. Health Trainer clinics have been set up in 13 practices with more to follow. A 'core offer' and clear referral pathways for GP practices has been circulated to increase access to all components of the HAA programme.

3.4 Front line staff confidently raise the issue of lifestyle behaviours and provide confident brief interventions and sign posting		
LEAD: Julie Graham – Acting Head of Health & Wellbeing **ACTION A:** A minimum of 500 front line staff are trained each year		**Action complete for year.** 691 staff have been trained to date Timetable of courses throughout the year developed and publicised. Target audience widened. Whole-scale team training of various teams in Social Services. Resource pack to accompany training has been developed and is provided to all participants to facilitate discussion with clients.
3.5 Develop and implement a plan for increasing health gain in the most deprived areas of Wirral		
LEAD: Julie Graham – Acting Head of Health & Wellbeing (Healthy Communities) **ACTION A:** Develop and implement a Health Action Area Plan to accelerate health improvement in the 3% and 20% most deprived areas of Wirral		**Partially complete** This has been partially achieved. Each individual HAA team has action plans pertinent to their areas. An overarching HAA action plan incorporating new performance indicators from the 2010-2011 service specification will be produced. Plan to be developed will reflect changes as a result of the NHS Strategic Plan refresh. *Develop an integrated plan to improve health in the designated health action area (in addition ot plans for the HAA team)*
3.6 A strategic approach to social marketing is developed		
LEAD: Martin McEwan – Director of Engagement **ACTION A:** Review resources and programmes currently invested in promoting health and wellbeing to tackle health inequalities		**Action complete** A programme of activities to tackle the key health needs has been established and prioritised to identify the key areas of focus for social marketing activities. An agreed programme of activity, with alignment of campaigns has been agreed between NHS Wirral and Wirral Borough Council. A joint Public Health and Communications workshop has been held with colleagues across the Cheshire and Merseyside footprint to review options for greater alignment of campaigns across the Cheshire & Merseyside footprint. An audit of social marketing campaigns is currently being completed to identify where efficiencies could be maximised. Involvement in the Cheshire & Merseyside ChaMPs social marketing group is also established to share best practice and review health and wellbeing programmes and resources across the region. Endorsement for the Year of Health and Wellbeing has been incorporated in to NHS Wirral activities and plans to further strengthen messages around key health needs. A detailed evaluation of the Life Channel has been conducted to align campaigns to key health needs and ensure targeted messages in a timely fashion (i.e. to coincide with other local, regional and/or national campaigns)

LEAD: Martin McEwan – Director of Engagement **ACTION B:** Produce a fully resourced health and wellbeing 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		**Action in progress** Smoking, alcohol, CVD and Urgent Care social marketing campaigns are underway. Early discussions with PCTs across Merseyside regarding a joint Safe-Sleeping Campaign are on-going. A joint Social Marketing Officer post between the Communications & Engagement Directorate and Public Health is currently being recruited. This post will support the development, delivery and evaluation of social marketing campaigns to deliver against NHS Wirral key public health targets and strategic objectives. An agreed programme of activity, with alignment of campaigns has been agreed between NHS Wirral and Wirral Borough Council. Indepth insights research (via focus groups, on-street surveys and MOSAIC profiling) across a number of campaigns has been conducted which builds a clearer picture of audience preferences therefore shaping targeted communications approaches. An audit of communications activities is on-going and press activity closely monitored to shape future plans for key health need campaigns (i.e. what works well, what the media pick up on etc.). An account management model has been established within the Communications Team to actively support each of the key health needs and to ensure dedicated resource for communications activity planning
3.7 Increase opportunities to provide information about affordable warmth for vulnerable adults		
LEAD: Jan Gill – Head of Health Protection **ACTION A:** Provide affordable warmth information alongside flu campaign		**Action completed** 10,000 card thermometers were printed and distributed via Localities in October 2009 to be included in invitations for seasonal flu vaccination along with Dept of Health Winter Warmth booklets

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

4.1 Reduce under 18 conceptions by 50% (LAA NI 112)		
LEAD: Marie Armitage – Joint Director of Public Health **ACTION A:** Implement the Teenage Pregnancy Priority Action Plan		**Action completed, monitoring of target is ongoing** Wirral has experienced significant improvements in its teenage conception rate and has now observed a 21% reduction since the 1998 baseline. Recent data shows that there were 249 teenage conceptions in Wirral in 2008, equating to 40.0 per 1000 females aged 15-17 years old, compared to the 2007 rate of 47.4. A multi-agency approach continues to be implemented to reduce the number of unwanted teenage conceptions and support those young people who choose to become parents at an early age. Future work will aim to further develop targeted support for those areas within Wirral which still have a higher than average teenage conception rate and will also act upon recommendations made in the refreshed National Teenage Pregnancy Strategy.
4.2 Reduce the number of children seriously injured or killed due to accidents		
LEAD: Dave Rees – Group Leader Road Safety Services **ACTION A:** Reduce the number of children seriously injured or killed in road traffic accidents (LAA NI 48)		**Action is co-ordinated through Community Safety Partnership** Year end actual figure 2009-2010 = 14.5. Previous year's calculation: Child KSI total for 2008 = 14 The target for the percentage change since the base period (average of KSI's in 2005; 2006 & 2007) compared to average of KSI's in 2006; 2007 & 2008 was 16.3% This was derived using target data (based on straight line projection between last known KSI info for 2007 and our ultimate target of 19 KSI in 2010) instead of actual data for 2008. The actual performance using the data provided by the police for 2008 is 25.0% Review of multi-agency RoadSafe Action Plan focuses existing and additional resources against high-risk casualty and road user groups. Analysis of KSI casualty data has shown additional actions from last year having overall positive effect on reducing casualties, however actual KSI casualty reduction was not as good as expected during 2009. *Continue plans to reduce NI 48*
LEAD: Anne Tattersall – Head of Health & Wellbeing (Children & Young People) **ACTION B:** Review and revise child accident prevention programmes		**Action partially completed** Following multi agency review of the Safety Equipment Scheme decision made for Rospa and Moss Alliance to work alongside each other throughout the period of Rospa funding and for both organisations to take part in training organised through Rospa *Fully implement findings from review*

4.3 Reduce the proportion of the population that are obese, starting with children and families		
LEAD: Anne Tattersall – Head of Health & Wellbeing (Children & Young People) **ACTION A:** Reduce the proportion of children aged 4-5 (LAA NI 55) years and 10-11 years that are overweight and obese		**Target monitored as part of LAA and strategic plan** NCMP results for 2007/08 were as follows: Reception year saw 13.1% overweight and 9.6% Obese whilst Year 6 saw 15.1% overweight and 19.1% obese. NCMP results 2008/09 were released December 2009. The results are as follows: Reception year saw 14% overweight and 9.6% obese and Year 6 saw 14.1% overweight and 20.6% obese. This means that the proportion of children overweight has only reduced in year 6. Six schools identified for additional support through the Active Lifestyles Programme and have attended the one day obesity awareness training. Feedback letters sent to parents for second year running to inform them about their child's weight. Aggregate data to be shared with schools through cluster groups and media strategy agreed to improve public perceptions of programme following recent negative publicity. NHS Wirral identified as a good example for NCMP data sharing as part of DH research NHS Obesity Programme Board in place to monitor contract compliance and impact on obesity through specialist weight management provision. In addition, plans in place to develop multi agency Obesity Steering Group across the Children's Trust partnership with initial meeting to canvass commitment to be held 23.4.10 and agree action plan to deliver on targets *Revise and implement plans to achieve a reduction*
LEAD: Anne Tattersall – Head of Health & Wellbeing (Children & Young People) **ACTION B:** Review and implement the Child Obesity Priority Action Plan		**Action progressing well** Obesity Programme Board established October 2009 to oversee the delivery of the strategic commissioning plan to include monitoring of the NCMP for 2009/10. Child Obesity is a priority area within the Being Healthy Strategic Action Plan (strand of Children & Young Peoples Plan).
LEAD: Anne Tattersall – Head of Health & Wellbeing (Children & Young People) **ACTION C:** Review and revise care pathways for preventing and treating child obesity		**Action completed** Childhood obesity care pathway in place and continues to be used. Care pathway for obese pregnant women in developmental stage.

LEAD: Anne Tattersall – Head of Health & Wellbeing (Children & Young People) **ACTION D:** Increase breast feeding rates with a focus on most deprived areas		**Target monitored as part of the Strategic Plan** The breastfeeding initiation rate has increased from 429 – 51% in Q4 09/09 to 530 – 58.5% in Q3 09/10. However, breastfeeding maintenance rates remain static. UNICEF breastfeeding training group set up to co-ordinate training for all relevant disciplines across Wirral. Training plan for 2010 produced and Breastfeeding care pathway in development. Breastfeeding social marketing launch confirmed for 22nd June – posters, leaflets and website have been produced. Breast feeding peer support programme commissioned to support breast feeding mothers with focus on 20% mothers from deprived areas. Coordinator and volunteers trained to support new mothers from April 2010. Service launched at Arrowe Park Hospital 13.4.10 – received with much enthusiasm and commitment from midwifery services. *Review plans for timely achievement of breast feeding maintenance targets*
4.4 Protect children from the harmful effects of tobacco		
LEAD: Neil Perris – Head of Public Health Provider Services **ACTION A:** Set and achieve a target to reduce the proportion of women who continue to smoke through pregnancy		**Action completed. Ongoing monitoring of target required** Target set was 12, years performance is 47. During the first 3 quarters of 09/10 the Specialist Service has helped 24 pregnant women stop smoking with a success rate of 57%. During 08/09 the annual total of pregnant women stopping smoking was 26 with a 44% success rate *Whilst the stop smoking service has increased engagement and success with pregnant women, overall numbers of women continuing to smoke throughout pregnancy have risen. Plans to achieve a reduction should be set in place*
LEAD: Neil Perris – Head of Public Health Provider Services **ACTION B:** Implement a campaign to reduce childhood exposure to second hand smoke, including training of frontline staff		**Action complete but campaign ongoing** 150 + Smokefree Homes pledges have been made in the community. 10 teams have been trained to deliver the programme.

4.5 Enable young people to access high quality education, training and employment that provides them with positive life choices		
LEAD: Sheila Lynch – Connexions **ACTION A:** Reduce the proportion of 16-18 year olds that are not in education, employment or training (LAA NI 117) **ACTION B:** Set in place policies in the LAA partnership agencies to support the training and access to local jobs for Wirral young people		**Action is monitored via LAA** The current 16-18 year old NEET figure at end of Q4 was 8.48%. This equates to 875 young people out of a cohort of 10316.This is a positive reduction against performance at the same time last year when the figure was 9.66%. The Nov/Dec/Jan 3 month average reported figure for Wirral was 8.90%. A borough wide task group has now been established, chaired by the Principal of Wirral Met to understand and address the issues faced by NEET young people within a strategic context. Continue to review and implement plans to reduce NEET

Strategic Priority 5: Improve and share data and intelligence on health and wellbeing

5.1 Develop shared ownership of progress towards achieving health inequalities targets		
LEAD: Tony Kinsella – Head of Performance & Intelligence **ACTION A:** Identify key health inequalities metrics and develop reporting (eg MIS)		**Q4 Update (Sue Drew)** A new basket of indicators is being developed to monitor progress on inequalities. System by which access to the monitoring data is given throughout key stakeholders is still to be decided. The JSNA provides a deep dive into health inequalities data and is used to produce a Health Inequalities Annual Report for 2009/10 *Further develop health inequalities metrics as an indication of progress against key outcomes*
5.2 Increase use of shared data and intelligence		
LEAD: Tony Kinsella – Head of Performance & Intelligence **ACTION A:** Develop and implement a Shared Data and Intelligence Plan for health & Wellbeing		**Action progressing** Key workstreams have been provisionally drafted and are to be agreed at the JSNA Executive group meeting in May. *Complete development and implementation of plan*
5.3 Neighbourhood Action Plans identify gaps and opportunities to improve health and wellbeing		
LEAD: Julie Graham – Acting Head of Health & Wellbeing (Healthy Communities) **ACTION A:** Health & Wellbeing data and intelligence available to neighbourhood management programmes in the 20% most deprived areas are reviewed and made available to compliment local intelligence		**Action completed** Neighbourhood plans produced for each programme including public health data. JSNA now available in web format to be fully accessible to partnership. Additional health and well-being needs assessment findings to be included in JSNA web site. Physical Activity Needs Assessment being carried out in most deprived areas to precede procurement project that will include target group in selection panel BME Health Needs Assessment completed Awaiting final report from Mental Wellbeing Study HIV/Aids needs assessment currently underway