



**East Suffolk and
North Essex**
NHS Foundation Trust

Addressing Health Inequalities at ESNEFT

Dr Angela Tillett, Chief Medical Officer

3rd June 2021



Health inequalities are the preventable, unfair and unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental and economic conditions within societies” (NHS England)

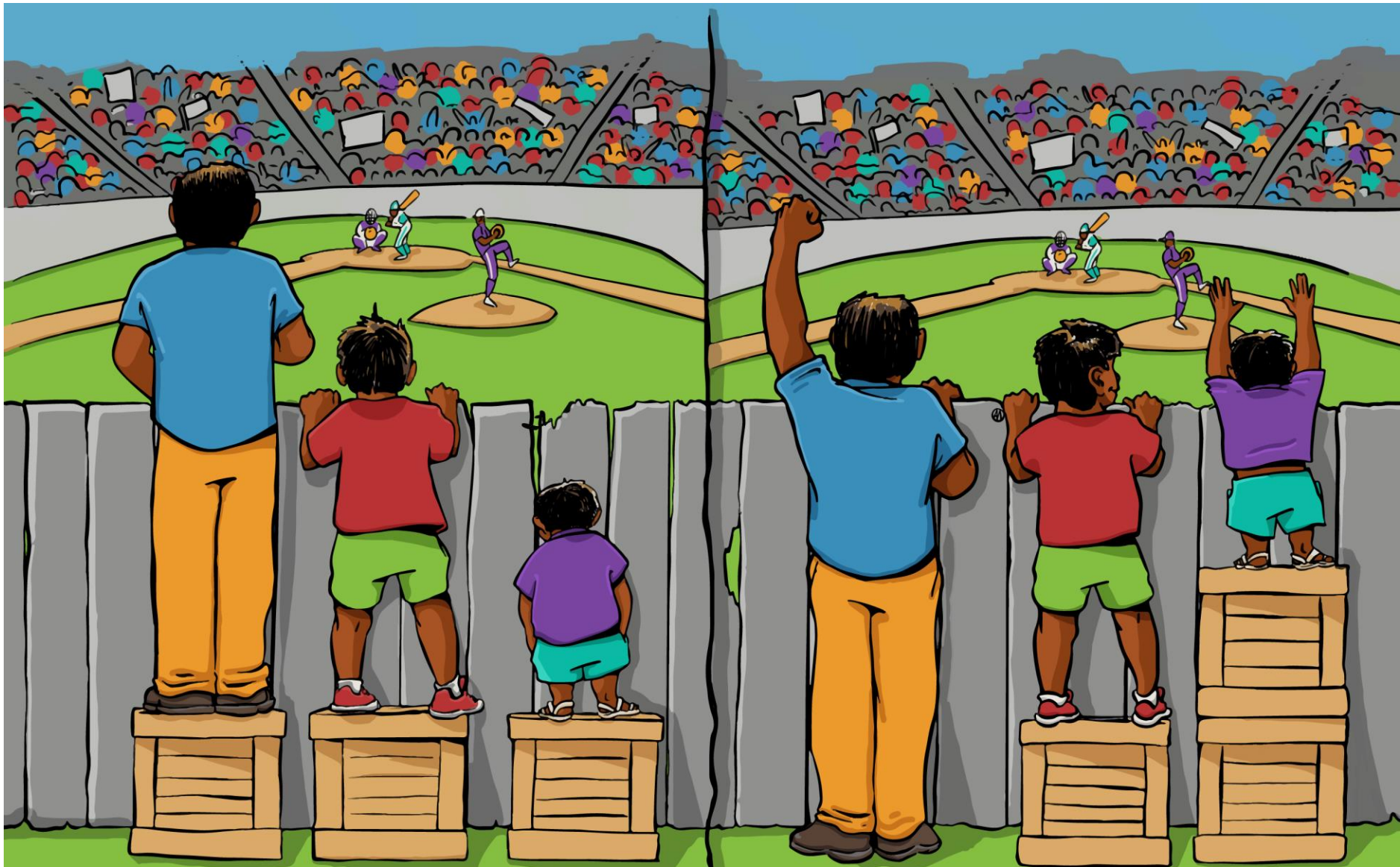
<https://www.england.nhs.uk/about/equality/equality-hub/resources/>



Inequality and Inequity

- Equality means treating everyone the same/providing everyone with the same resource
- **Equity refers to the provision of varying levels of support—based on specific needs—to achieve greater fairness of treatment and outcomes**





EQUALITY

EQUITY

National Guidance

'2021/22 Priorities and Operational Planning Guidance' Systems are required to demonstrate that plans for elective recovery will:

- Use waiting list data (pre and during pandemic), including for clinically prioritised cohorts, to identify disparities in relation to the bottom 20% by Index of Multiple Deprivation (IMD) and black and minority ethnic populations
- Prioritise service delivery by taking account of the bottom 20% by IMD and black and minority ethnic populations for patients on the waiting list and not on the waiting list, including through proactive case finding
- Use system performance frameworks to measure access, experience and outcomes for black and minority ethnic populations and those in the bottom 20% of IMD scores
- Evaluate the impact of elective recovery plans on addressing pre-pandemic and pandemic-related disparities in waiting lists, including for clinically prioritised cohorts
- Demonstrate how the ICS's SRO for health inequalities will work with the Board and partner organisations to use local population data to identify the needs of communities experiencing inequalities in access, experience and outcomes and ensure that performance reporting allows monitoring of progress in addressing these inequalities".
- Health inequalities are the preventable, unfair and unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental and economic conditions within societies" (NHS England)

<https://www.england.nhs.uk/about/equality/equality-hub/resources/>



What are we doing at ESNEFT?

System approach improving access to services across Alliances

- Virtual ward rounds in nursing homes, virtual clinics
- Reconfiguration of services : AMSDEC outreach, diagnostic hub,
- Improved access to translating services, tailored support maternity for black and ethnic minority communities

Within the Trust

Inequalities working group – links with wider quality programmes such as mental health, end of life steering group,

- 2 subgroups : adult and Children and YP nurses, doctors, AHP, BI colleagues

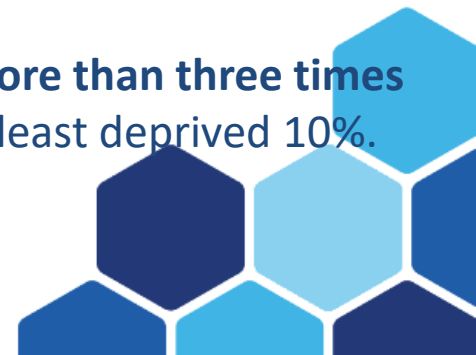
but first ... Data !



This analysis investigates the relationship between obesity and deprivation, nationally and within the ESNEFT catchment

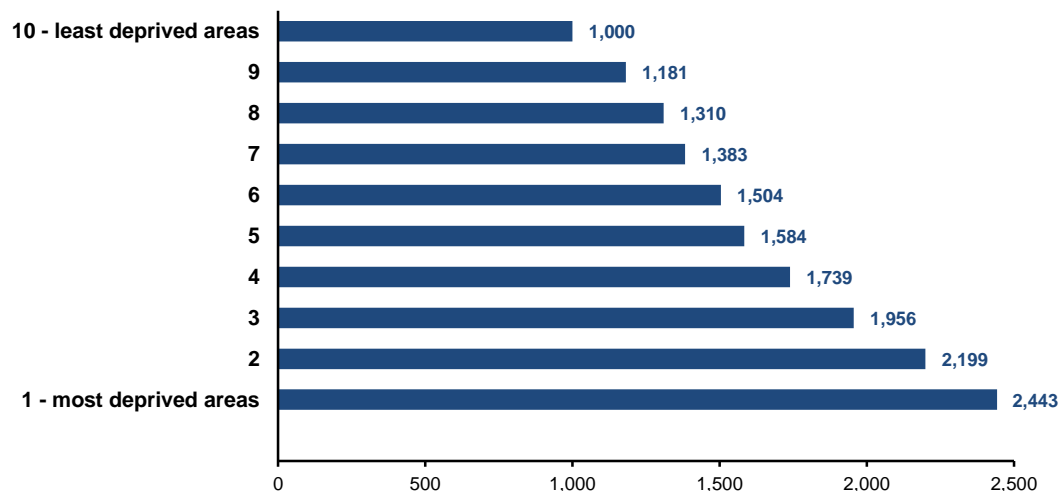
KEY FINDINGS

- Nationally, there is a clear relationship between deprivation and adult obesity rates. **Adult obesity rates are 2.4 times higher in the most deprived areas compared to the least deprived.**
- There is a clear and significant relationship between deprivation and child obesity rates, both nationally and within the ESNEFT catchment. **Child obesity rates are around three times higher in the top 10% most deprived areas compared to the 10% least deprived.**
- Obesity as a primary or secondary diagnosis was 50% more likely in ESNEFT patients in the 10% most deprived areas in contrast to the 10% least deprived areas [for inpatients admitted between 1 Apr 2019 to 31 Mar 2021].
- The rate of hospital spells per 100k where obesity was a **factor is more than three times** higher for patients from the top 10% deprived areas relative to the least deprived 10%.

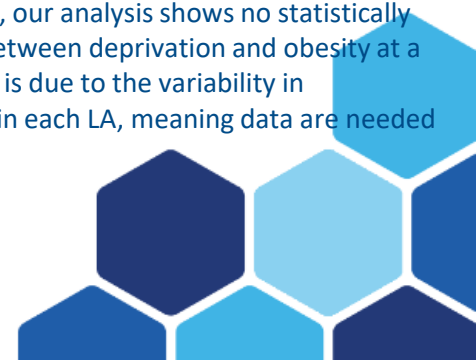


Nationally, there is a clear relationship between deprivation and adult obesity rates. Adult obesity rates are 2.4 times higher in the most deprived areas compared to the least deprived

Figure 1: The proportion of obese cases per 100k population in different deprivation deciles

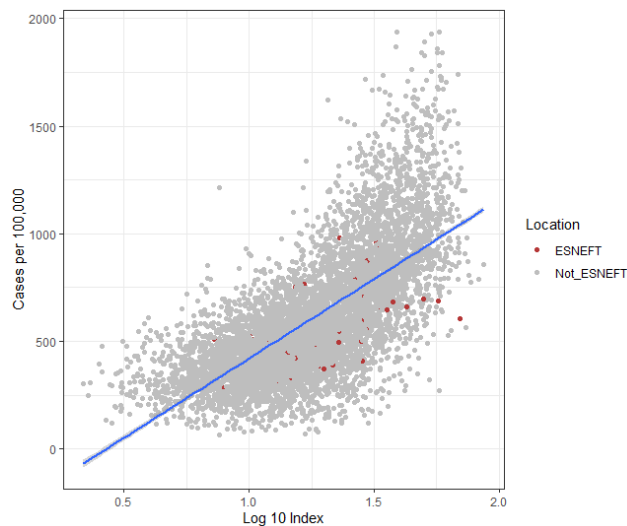


- Nationally in 2018-19, there were 11,117 hospital admissions directly attributable to obesity; an increase of 4% on 2017/18, when there were 10,660 admissions.
- There were 876K hospital admissions where obesity was a factor; an increase of 23% on 2017/18, when there were 711K admissions.
- **There is a clear relationship between deprivation and adult obesity rates, with obesity rates higher in the most deprived areas.**
- According to NHS Digital published data for 2018-19, admissions* in the 10% most deprived LSOA's are more than 2.4 times greater than in the 10% least deprived areas (Figure 1) during FY 17/18.
- Adult obesity rate data are only available publically at Local Authority level. However, our analysis shows no statistically significant relationship between deprivation and obesity at a local authority level. This is due to the variability in deprivation present within each LA, meaning data are needed at MSOA/LOSA level.



There is a clear and significant relationship between deprivation and child obesity rates, both nationally and within the ESNEFT catchment. Child obesity rates are around three times higher in the top 10% most deprived areas compared to the 10% least deprived

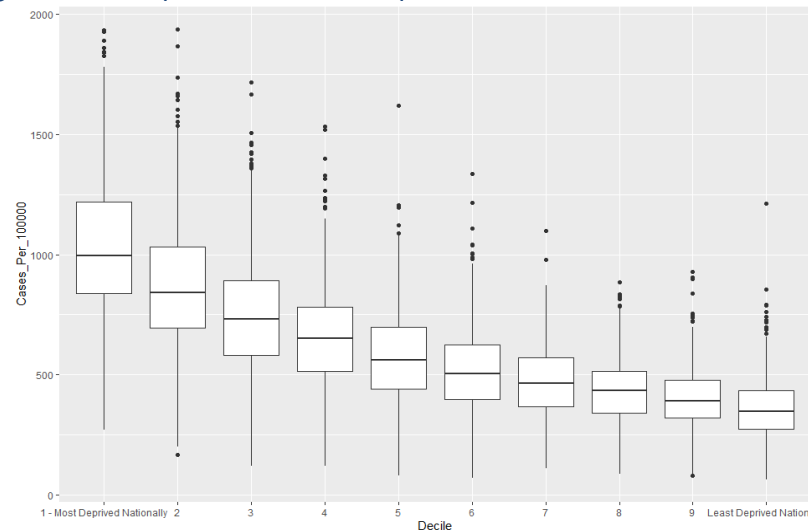
Figure 2: The relationship between Health Deprivation (x-axis) and obesity rates per 100k in Year 6 children (MSOA level)



- Child obesity is significantly higher in the most deprived MSOAs (top 10%) compared to all other MSOAs ($P < 0.05$)
- The largest difference is observed between the top decile and bottom decile, where cases per 100k are 678 lower than those in the most deprived areas ($P < 0.001$).

- Child obesity information is publically available at MSOA level, meaning we can investigate the relationship between child obesity rates and deprivation.
- There is a strong positive relationship between cases of obesity in Year 6 children and deprivation (Figure 2). This is observed at national and ESNEFT geographies ($P < 0.001$). Child obesity rates are around three times higher in the top 10% most deprived areas compared to the 10% least deprived.
- Of the different domains of deprivation, income deprivation has the strongest relationship with child obesity, followed by health deprivation. Both relationships are highly significant ($P < 0.001$).
- In the ESNEFT area, cases of obesity were highest in Witham (Braintree 016) at 980.22 per 100k population, and lowest in Wivenhoe (Colchester 017 MSOA) at 267.07 per 100k population.

Figure 3: A Comparison between deprivation deciles and rates of child obesity



Admissions for ESNEFT services where obesity was a factor are around 50% more likely amongst patients from the most deprived areas compared to the least deprived areas within our catchment

- Between 1 Apr-21 and 4 Mar-21, the rate of admissions with a primary or secondary diagnosis of Obesity per 100k population in the ESNEFT Catchment area was the following:
 - Suffolk – 2,168 per 100k
 - Essex – 1,469 per 100k
 - ESNEFT Catchment Area – 2,388 per 100k
 - This compares to the national average rate of 1,649 per 100k
- ESNEFT admissions where obesity was a factor increase with the level of deprivation (Figure 4):
 - Of the 19,232 admissions where obesity was a factor, admissions were around 50% more likely for patients from the most deprived areas (IMD decile 1) compared to the least deprived areas (IMD decile 10).
- The rate of hospital spells per 100k where obesity was a factor is more than three times higher for patients from the top 10% deprived areas relative to the least deprived 10% (figure 5).
- It is not possible to conclude the relation between admissions where obesity was the primary diagnosis and deprivation because the sample of cases (43) is too small. Similarly, we cannot assess the relationship between deprivation and obesity related procedures (e.g. bariatric surgery) due to small sample sizes.

Figure 4: Proportion of admissions where obesity is a factor by deprivation decile

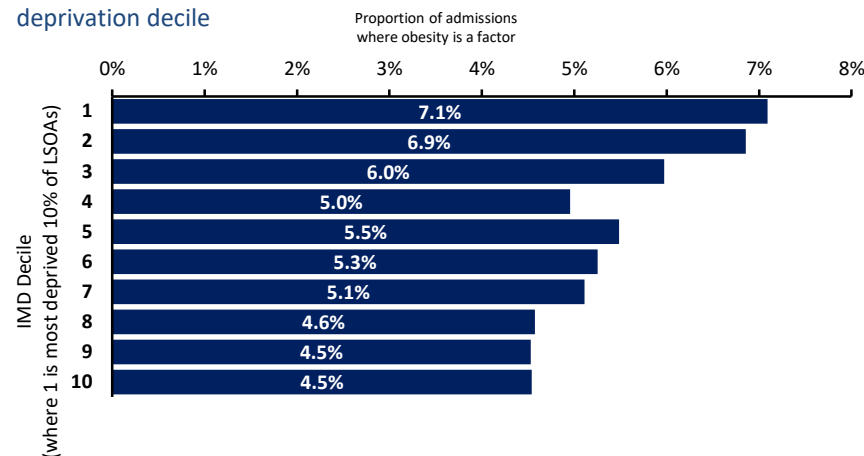
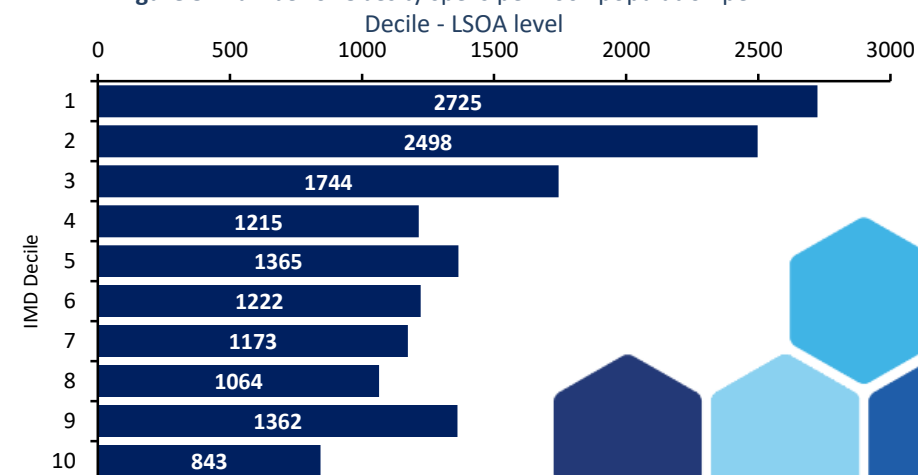


Figure 5: Number of Obesity spells per 100k population per IMD Decile - LSOA level



Deprivation and RTT waiting list

The analysis identified a statistically significant difference between deprivation deciles and RTT Weeks Wait ($p < 0.05$) which was driven by differences in short and long waits between the top and bottom deciles:

- Relative to the population size, a greater than expected proportion of patients in the most deprived decile have waited < 2 weeks;
- Relative to the population size, a greater than expectation proportion of patients in the least deprived decile have waited > 52 weeks (Figures 4 and 5).

However, the analysis could not conclude that there is a direct relationship between deprivation and RTT weeks wait and further work will need to be done. Further work is needed to determine the interaction between deprivation and diagnoses, as well as other demographic factors such as age.

Deprivation Decile	RTT Weeks Wait						ESNEFT Population
	<2	2-6	7-12	13-36	37-51	52+	
Most Deprived	10.6%	5.5%	5.1%	5.4%	4.9%	4.4%	3.6%
2	9.7%	10.5%	12.1%	12.2%	13.2%	14.7%	11.4%
3	9.7%	9.1%	7.2%	9.5%	9.6%	9.5%	8.7%
4	7.7%	8.7%	7.0%	7.3%	7.8%	5.5%	8.0%
5	10.9%	12.6%	13.0%	12.5%	11.6%	11.5%	11.5%
6	8.9%	10.0%	9.5%	9.4%	9.3%	8.2%	12.4%
7	15.1%	14.7%	15.7%	14.8%	14.6%	14.7%	14.5%
8	16.1%	15.3%	15.1%	16.0%	17.0%	16.3%	19.1%
9	6.2%	8.3%	9.0%	8.3%	7.0%	8.6%	7.4%
Least Deprived	5.2%	5.3%	6.2%	4.8%	4.9%	6.6%	3.5%

RTT Wait breakdown by deprivation decile in ESNEFT catching area

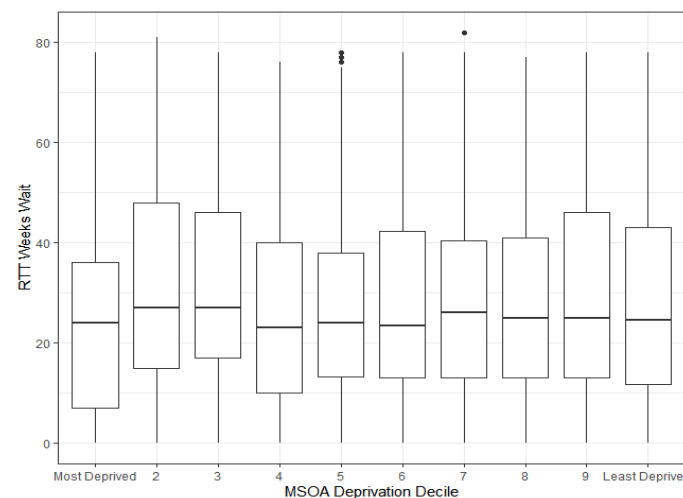


Figure 5: Proportions by Deprivation Decile adjusted to population size in ESNEFT catching area per 100,00s

Inequalities working group: our approach

- Recognise key (non-medical) determinants of health
- Adapt clinical conversation from focus on “ medical illness” to include healthy living and prevention
- Focus on conditions that have most negative impact on outcomes and affect a broad proportion of our patients Link closely with Alliance and ICS partners for consistency of message
- Feasible for clinical teams to support in terms of time
- Provide the tools: training in Making Every Contact Count MECC and supporting resources
- Involve patients and carers in programme



What is MECC?



Behaviour change interventions mapped to NICE Behaviour Change: Individual Approaches
<https://www.nice.org.uk/Guidance/PH49>

- MECC is an approach to **behaviour change** that uses the millions of day-to-day interactions that organisations and people have with other people to support them in making **positive changes to their physical and mental health and wellbeing**.
- Drawing on behaviour change evidence, MECC maximises the opportunity within routine health and care interactions for a **brief or very brief discussion** on health or wellbeing factors to take place.

Making Every Contact Count



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#QuitForCovid

**30 Seconds to
save a patient's life**

ASK

Do you smoke?

ADVISE

The best way to stop smoking is
with a combination of medication
and support

ACT

Refer to OneLife Suffolk
01473 718193
or their GP or local pharmacy



Medical Directorate Inequalities Programme

Adults

Project Groups

Eating Well	Tobacco Treatment
Penny Cason	Jonathan Douse
Catherine Brosnan	Martin Sterry
Selina Lim	Public Health Teams Essex/Suffolk CCs
Dan Coates	Sarah Orr
Gillian Gatiss	Alex Vester
David Gannon	

Children & Young People

Project Groups

Eating Well	Asthma Management
Andrea Turner	Andrea Turner
Sally Cornish	Bhupinder Sihra
Rachel Fletcher	Imogen Rose
Anna Groom	Sally Cornish
Penny Cason	
Lindsey Mowles	

BI providing
population
data

Mental Health

PHE
Alliance partners

MECC
Catherine Brosnan/
Penny Cason

Children & Young People - Approach

Project Groups	
Eating Well	Asthma Management
<ul style="list-style-type: none">• Universal Offer plus• Pilot for 14 patients over 20 weeks• Focus on CO15 catchment initially• Weight reduction and management clinic focusing on lifestyle approach	<ul style="list-style-type: none">• Identify GP surgeries and pharmacies in deprivation areas of Tendring and Ipswich• Work with GPs to establish if Asthma Management Plans are in place and annual reviews carried out• Develop information pack for GPs• Deliver education sessions for GPs



Adults - Approach

Project Groups

Eating Well

- Working with partners across the system to join up work streams e.g. Adult Healthy Eating Group, Obesity Strategy group
- Link into Nutrition Improvement Project to address Malnutrition (both obesity and underweight)
- Working with partners to address staff wellbeing including eating well (link with catering providers, staff support forums etc)

Tobacco Treatment

- Working with partners to access funding from ICS
- Working with partners to provide training for staff in tobacco treatment



Next steps

- Further data needed to understand access to services and appropriate change to clinical services to improve equity
- Improve data quality/collection: “ ethnicity not stated” help our patients understand why it is important we ask and what the barriers are to them providing this information
- Trust – wide approach to addressing inequalities- divisional teams, quality programme
- Remember our staff are the most precious resource: community ambassadors
- Train and support staff in MECC approach
- We have to start somewhere Pilot, adapt, adopt and spread - healthy eating, tobacco treatment, asthma ..

