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Addressing Health Inequities at ESNEFT Progress Update

Dr Angela Tillett, Chief Medical Officer

Patient Safety Group: 15th February 2022
CRG: 22nd February 2022
Trust Board: 3rd March 2022

ESNEFT approach to tackling Inequities

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Quality Improvement Programme

BI providing population data

Inequities Working Group

PHE
Alliance partners

Adults

Healthy Eating Project
Tobacco Treatment

Children & Young People

Healthy Eating Project
Asthma Management

Making Every Contact Count (MECC)

Community Diagnostic Hub (Tendring residents priority)

Clinical Prioritisation/ LD patients

Social Prescribers

Virtual Clinics

BI Data Analysis

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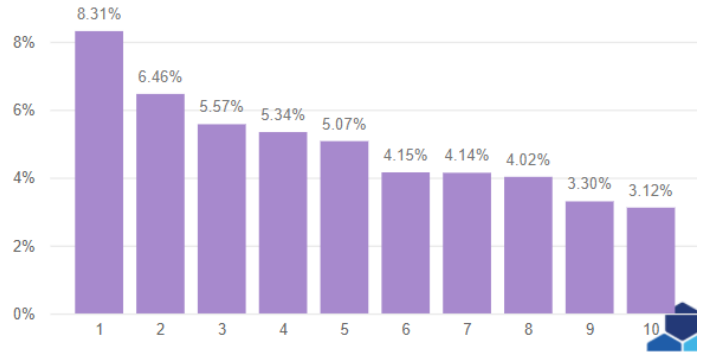
The pandemic shone a light on health inequalities. ESNEFT have established a programme of work to identify and mitigate local health inequalities. This is being implemented through the Trust's Inequalities Working Group. Here we report on some of the analyses for this group.

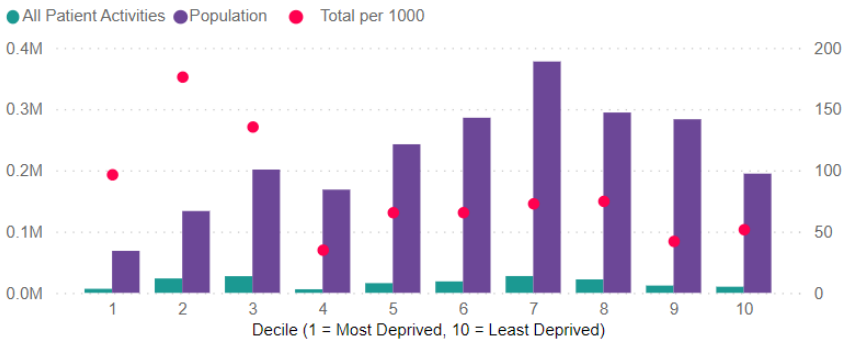
Did not attend rates increase with deprivation and is c. 2.7 times higher for patients from the most deprived decile compared to the least deprived

Outpatient Did Not Attend rate, by deprivation decile (1=most deprived, 10=least deprived)



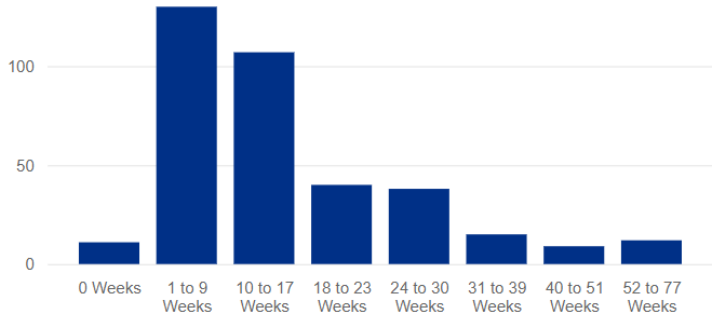
The ED attendance rate (attendances per capita) is highest for patients from the most deprived areas

ED attendances by population and deprivation decile (1=most deprived, 10=least deprived)



Patients with learning disabilities and difficulties on the RTT PTL have been identified, in part through data sharing with local authorities

Patients with learning difficulties and disabilities on the RTT PTL



Further work is being undertaken to assess the evidence for socio-economic inequalities across a range of health outcomes and healthcare services, as set-out in the NHSE Core20PLUS strategy.

A predictive analytics model is being built by BI to predicted patients most likely to DNA. Behavioural science research with University of Surrey is also being explored to understand the behavioural drivers of DNAs.

Analytical Framework for Health Inequalities

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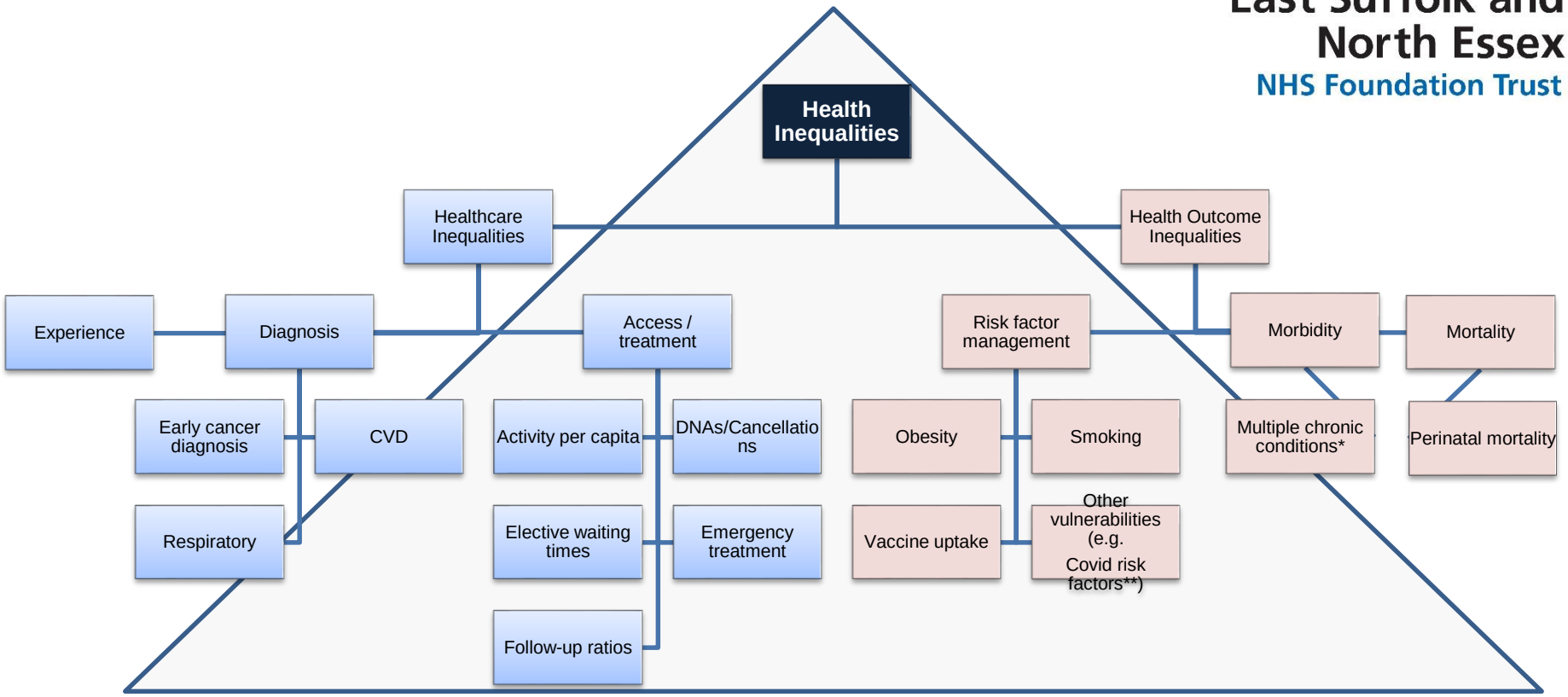

Place - IMD 1 & 2 population/socio-economic gradients; Rural/Urban; travel distance
People - Ethnic minority communities; Learning disabilities

*Hypertension, Asthma, Diabetes, Depression, Osteoarthritis, Coronary Heart Disease, Cancer, Atrial Fibrillation, Cerebrovascular Disease, Osteoporosis, COPD, Chronic Back pain, Peripheral Vascular Disease, Heart Failure, Chronic Kidney Disease, Serious Mental Illness, Dementia, Epilepsy, Physical Disability, Rheumatoid Arthritis, Inflammatory Bowel Disease, Intermediate Frailty Risk, Alcohol dependence, Pulmonary Heart Disease, Chronic Liver Disease, Learning Disability, High Frailty Risk Severe Heart Failure, Autism, Bronchiectasis, End Stage Renal Failure, Liver Failure, Parkinson's Disease, Multiple Sclerosis, Neurological Organ Failure, Severe Interstitial Lung Disease, Sarcoidosis, Sickle Cell Disease, Cystic Fibrosis

**Atrial Fibrillation, Bronchiectasis, Cerebral Palsy, Cerebrovascular Disease, Chronic Kidney Disease, Chronic Liver Disease, Congenital Heart Disease, COPD, Coronoary Heart Disease, Cystic Firbrosis, Dementia, Diabetes, Epilepsy, Heart Failure, Learning Disability, Multiple Sclerosis, Obesity, Other Chronic Respiratory Disease, Other neurological organ failure, Parkinsons Disease, Peripheral Vascular Disease, Pulmonary Embolism, Pulmonary Hearth Disease, Serious Mental Illness, Severe Asthma, Severe Interstitial Lung Disease.

ESNEFT Inequalities Strategy and Delivery Plan

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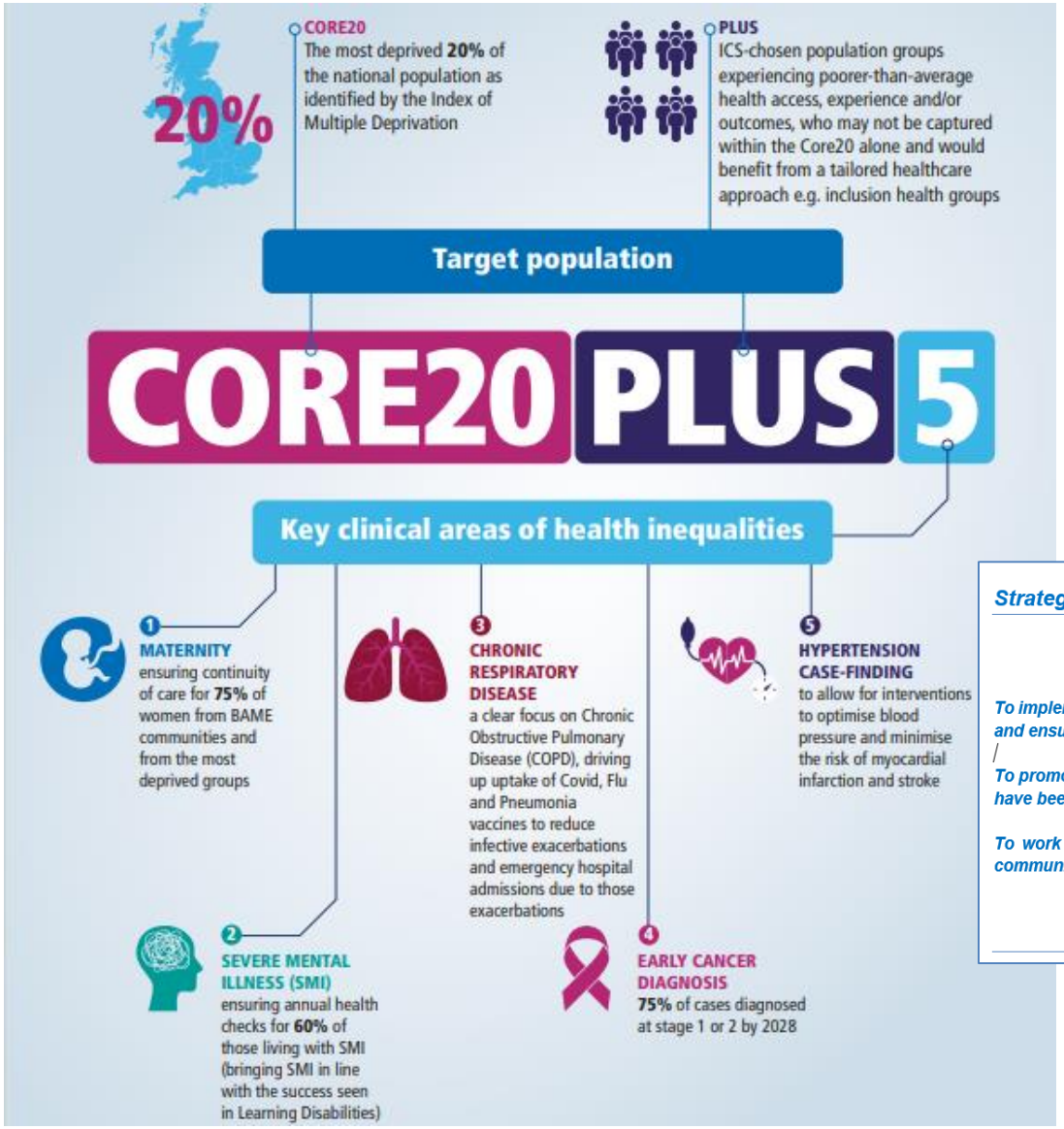

Strategic Aims

To implement population health management and personalised care approaches to improve health outcomes and ensure equitable access to our services within our localities.

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To promote self-care and keeping well to our patients and consider how we can reduce health inequities that have been magnified by the Covid pandemic.

To work with community partners and the ICS to align approaches and provide tailored support to our communities.

Adults: Tobacco Treatment

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NHS Long Term Plan:
By 2023/24, ***all people*** admitted to hospital who smoke will be offered NHS-funded tobacco treatment services.

- Working closely with ICS partners, a model of care for ESNEFT inpatients has now been developed – looking to phase the roll out. To potentially start April 2022
- Funding has now been secured for Year 1s and 2.
- Adaption of IT systems to ensure accurate recording of patients smoking status is being explored (development of E-forms within Evolve)
- Working with Provide and OneLife Suffolk to support the service within ESNEFT
- Data collection tool received and under review
- Recruitment for Tobacco Treatment Project Manager commenced

Adults: Healthy Eating

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- Refresh focus - Lead Nurses now identified: Deputy CNOs
- Working with partners across the system to signpost patients into healthy eating support services in Suffolk and Essex
- Working with ESNEFT Wellbeing Team to explore ideas and opportunities to support staff with weight management and nutrition
- Linking into Nutrition Improvement Project to ensure we are meeting individuals nutritional needs appropriately whilst on the in-patient wards
- Supporting the MECC approach by promoting healthy eating

C&YP: CO15 Pilot

NOURISH
improving physical and mental health

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Pilot Intervention – Healthy eating & lifestyle clinic

Focus on 14 CYP aged 10-16yrs in the CO15 postcode

Local clinic held at Clacton Football Club

Criteria: CYP identified as severely obese, meeting either of the following criteria –

BMI>98th centile and at least one identified co-morbidity OR

Extreme obesity - BMI > 99.6th centile (>3SD above mean)

Intervention

- Initial appointment – assessment, detailed history, examination, baseline investigations
- 20 week programme - alternating fortnightly MDT clinic / fortnightly group session
- Delivered by specialist paediatric dietitian, physiotherapist and youth worker
- Lifestyle approach
- Group sessions – fun physical activity, cooking / food prep activities
- Work with other organisations
  - Active Essex (supported by Sport England) – facilitate group sessions
- Participants all given Fitness Trackers and set individualised targets each week

Outcomes

- Increase in self-esteem
- Reduction in BMI / improved anthropometric measurements
- Change in other physical parameters – heart rate, ability to exercise
- Improvement in co-morbidities e.g. blood pressure, fatty liver, sleep apnoea

C&YP: CO15 Pilot

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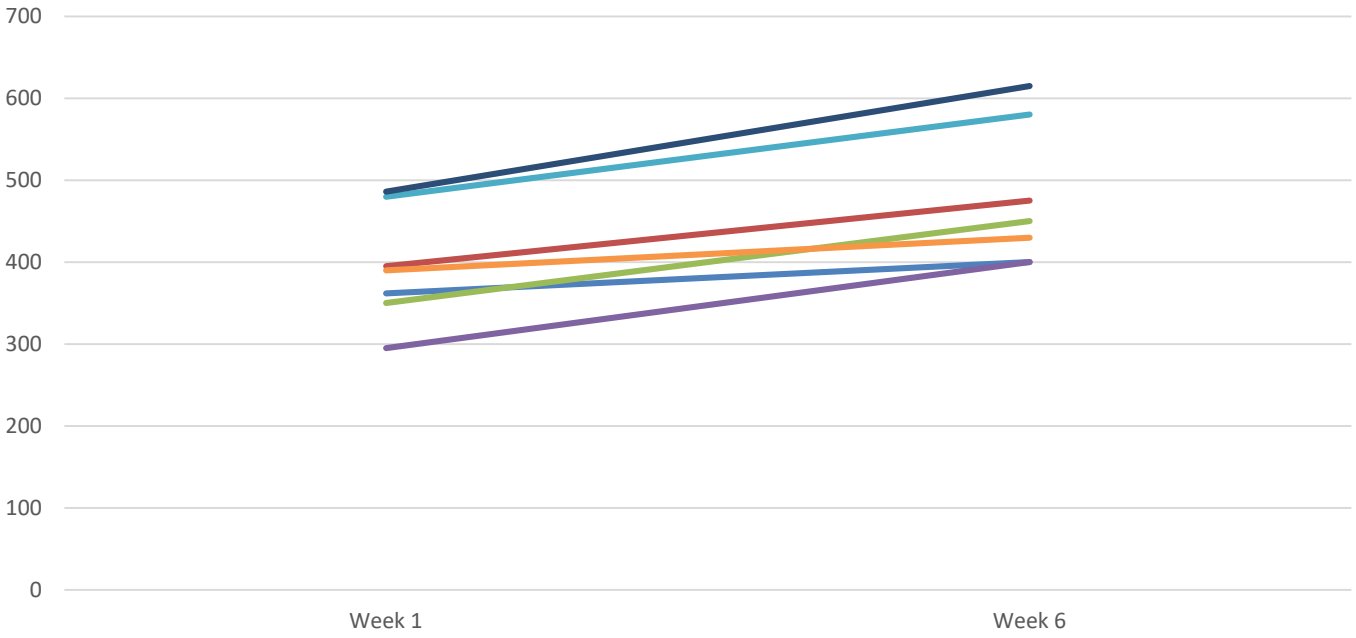
Fitness measure – distance walked in 6 minutes…. Progress so far



Summary

- Good engagement and attendance so far
- Enjoying working towards target goals between sessions (step chart)
- Whilst no weight reduction, CYP and families are engaging with activities and fitness appears to be improving

Making Every Contact Count (MECC) Progress…

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- Successful pilot in orthopaedic OPD Colchester: 103 patients offered help, 20.4% patients requested referral to either OneLife Suffolk or Essex Wellbeing Service.
- Positive and constructive feedback from staff and patients following pilot
  - One lady said: "she wanted to convey her heartfelt thank you as both the people she was referred to made contact on the same day. She felt she hadn't been listened to for 2 years and this cheered her up no end".
- Free CPD accredited staff training in MECC by OneLife Suffolk: 15 open sessions and 12 bespoke sessions training >260 members of staff.
- Successful application to the Accelerator Fund. Funding secured for p/t Band 7 Nurse to continue project until end March 22
- Established firm working relationships with OneLife Suffolk, Essex Wellbeing and social prescribers with Provide Essex

MECC – work underway

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- Project Plan developed to sustain and spread MECC starting in Clacton and Harwich OPD.
- Training: continuing current F2F, developing further training with OneLife Suffolk for different staff roles, developing a virtual training with Essex Wellbeing
- Continuing to measure satisfaction and progress outcomes with stakeholders (feedback, stories);
- Engaging in the wider system approach to support patients through the “Together We are Better” work
- Working with Patient Experience to have patient representative within MECC project team
- Develop the role of MECC champions to support sustainability.

Clacton Diagnostic Hub – Clacton District Hospital

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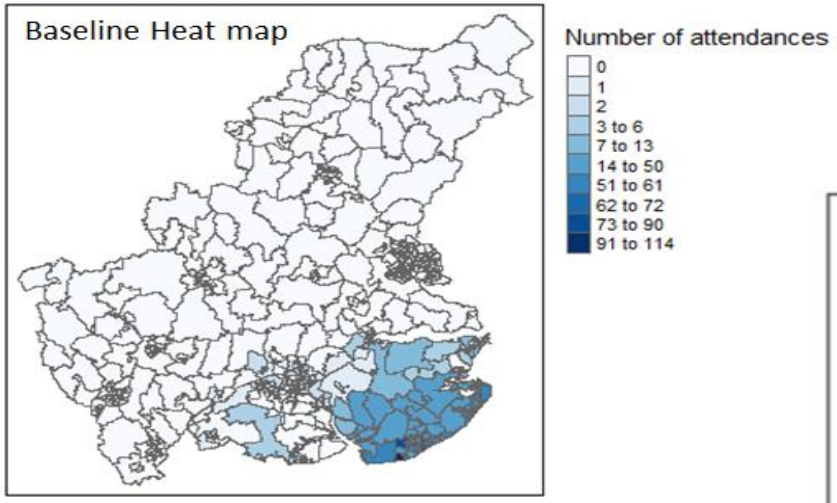
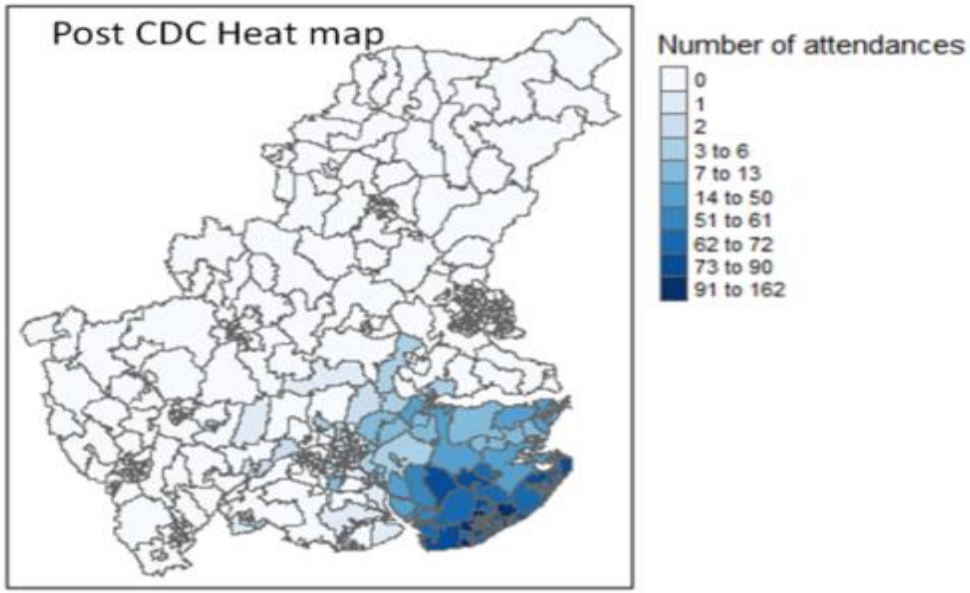
Since the beginning of October 2021 the CDC at Clacton has provided **35,000 tests, including 1,468 CT and 1,533 MRI.**

The CT and MRI capacity has been used to allow Clacton and Tendring patients to be seen closer to home – but not out of turn. Activity from this area has averaged 71% of the total utilisation for MRI and 83% for CT (see heat map below). The remaining capacity has then allowed Colchester patients the opportunity to be scanned earlier than originally planned.





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Next Steps

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- Develop draft ESNEFT Inequities Strategy working with key stakeholders
- Complete NHS Providers Inequalities Board Assurance Tool for April Board meeting
- Extend MECC pilot to Outpatients Urology Clinic at Clacton Hospital. Continue to spread and embed MECC Training
- Commence Tobacco Treatment Project
- Complete Nourish programme CO15 and evaluation. Explore further funding for scale up and spread
- Re-launch adult healthy eating programme
- Review DNA rates, including Clacton Diagnostic Hub data and identify themes – work with community groups, PCNS and HealthWatch to understand the challenges at community level to focus improvement
- Scope equity of access to cancer services