Trust Board
7th July 2022

East Suffolk and North Essex NHS Foundation Trust

Addressing Health Inequalities at ESNEFT Progress Update

Dr Angela Tillett, Chief Medical Officer

"Widening Equity for Local Lives"

ESNEFT approach to tackling Inequalities

NHS
East Suffolk and North Essex Foundation Trust

Quality Improvement Programme

BI providing population data

Inequalities 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

ESNEFT Inequalities Strategy and Delivery Plan

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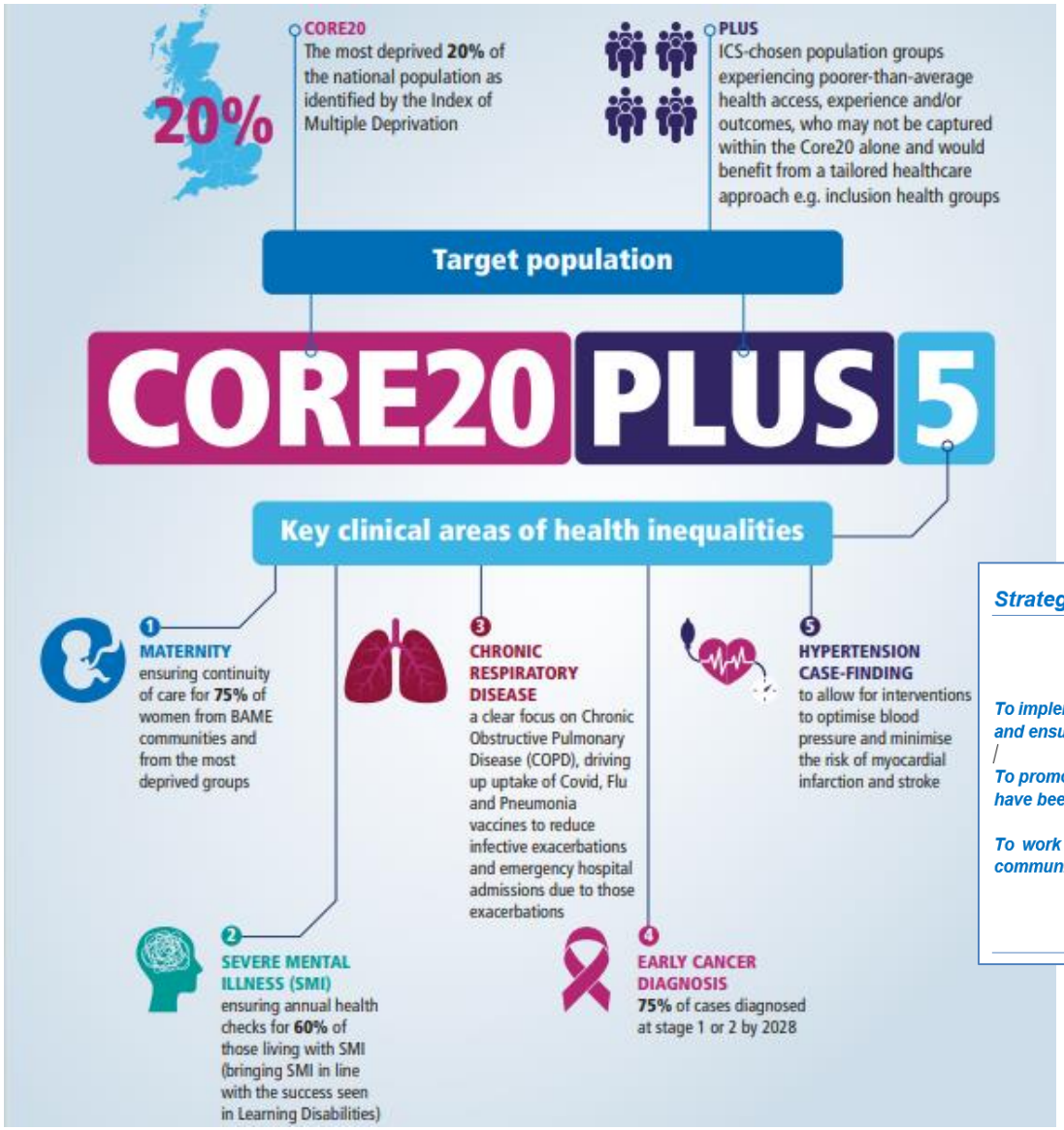

Strategic Aims

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 - Phased roll out to commence in respiratory wards and EAU in July 2022.
- Funding has now been secured for Year 1s and 2 of the service and patient pathways developed.
- Adaption of IT systems to ensure accurate recording of patients smoking status developed
- Recruitment of Smoking Cessation Advisors now complete by Provide and OneLife Suffolk
- Data collection tool reviewed and aligned with e-forms development
- Tobacco Treatment Project Manager recruited
- NRT protocol developed

Adults: Healthy Eating

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- Working with partners across the system to signpost patients into healthy eating support services in Suffolk and Essex
- Supporting the MECC approach by promoting healthy eating across sites
- Working with catering and housekeeping teams to review information and offer of meals for patients
- ESNEFT Wellbeing Team exploring further opportunities to support staff with weight management and nutrition
- Developing a questionnaire for staff to establish barriers to healthy eating choices and what options would be of benefit
- Development of an ESNEFT webpage linking to external providers and intranet page linked to Wellbeing hub

C&YP: CO15 Pilot

NOURISH
improving physical and mental health

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Pilot Intervention – Healthy eating & lifestyle clinic

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

Local clinic held at Clacton Football Club

Criteria: CYP identified as severely obese:

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 tests
- 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
  - Children's Society (supported by Sport England) – Healthy Activities practitioner to facilitate group sessions
- Participants all given Fitness Trackers and set individualised targets each week

C&YP: CO15 Pilot

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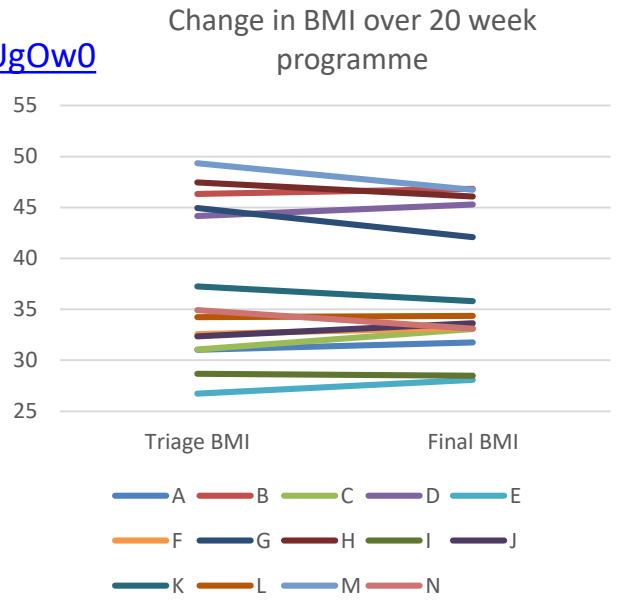
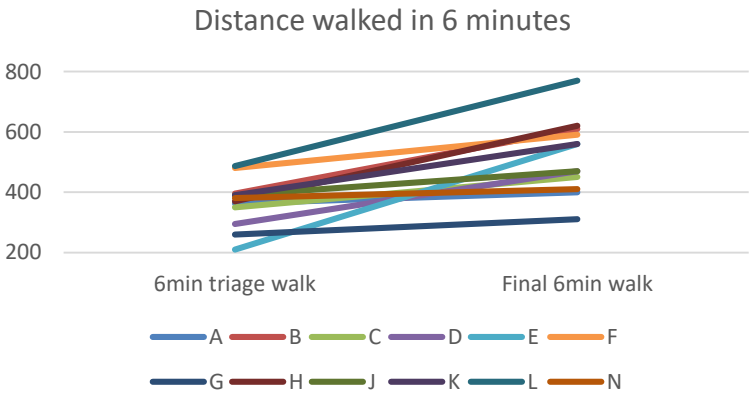
Outcomes

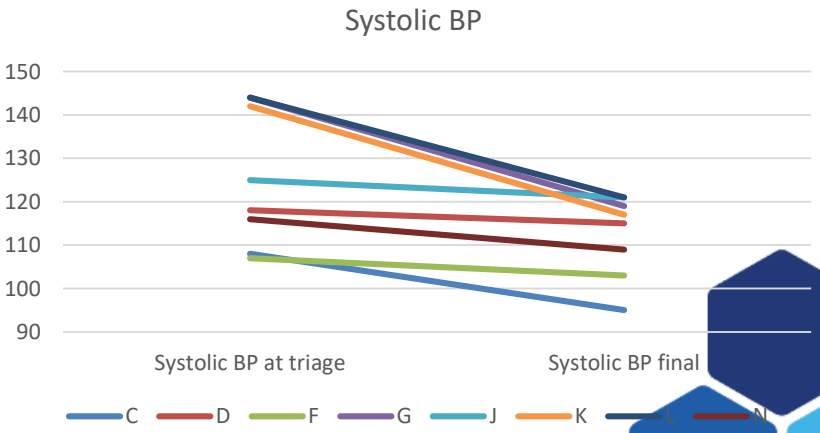
- Very good engagement and attendance
- Very positive feedback from children & families https://youtu.be/iqRD0WUgOw0
- BMI not consistently reduced although some did very well
- All showed improved fitness levels (distance walked in 6 mins – average increase 155m)
- All showed reduction in systolic BP



Self Esteem

- Improved self-esteem – assessed by Rosenberg Self-Esteem Tool
- Score out of 30, <15 consistent with low self-esteem
- All showed increased self-esteem score
- Average score START 14.6, FINISH 17.5





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C&YP: CO15 Pilot

Next Steps:

- Continuation of the programme being picked up by Active Essex
- Exploring possibility of residential trip at 3 months – e.g. Mersea Activity Centre
- Follow up consultation at 6 months with Dr Turner
- Explore pilot in Colchester and also Suffolk localities – funding to be identified for this

Making Every Contact Count MECC
Progress to date

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- Successful pilot in orthopaedic Outpatients : 103 patients offered help,
  20.4% patients requested referral to Essex Wellbeing Services
- Pilot team now running MECC as business as usual - Current referral rate **29.56%** to Provide, Essex Wellbeing services.
- MECC scale up and spread at Clacton/ Harwich (12 clinics), 4 Specialisms agreed (Urology, Gynaecology, Thoracics and Rheumatology) – includes Specialist Nurse Clinics in Urology and Nurse Flow rate clinics: referral rate **Feb 34%, March 19%** (this does not include 11 'ad-hoc' referrals from other clinics where staff initiated an invite for this service)
- MECC commenced at Ipswich main OPD in one clinic, 17th March 2022, so far referral rate **15.7%** to OneLife Suffolk services.
- Total of **50** clinics now running MECC
- Total patients referred to providers **211** from January – May 2022

MECC progress

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- Overall compliance of offer of MECC to every patient attending clinic: **91.8%**
- Reporting MECC to Patient Experience Group
- Free CPD accredited staff training in MECC by One-Life Suffolk: 10 sign up sessions delivered training >60 staff plus departmental sessions
- Implemented MECC information folders to support roll-out
- Patient invite proforma translated into six languages
- Patient invite proforma in large print (yellow paper) to support those with impairment.
- Exploring digital opportunities for referral – these include Evolve, new portal, Text reminders , Touch screens, patient invite proforma to go out with appointment letters and QR codes for self-referrals
- Identifying patient representative on MECC project team
- Shared outcomes from Provide Essex wellbeing services by priority me and potential feedback stories - currently exploring this too with Onelife Suffolk services
- Developing the role of MECC champions to support sustainability and continue to scale up and spread MECC

Inequalities & MECC

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To measure the impact of MECC on patients living in the most deprived areas within our catchment we looked at the top 10% areas of multiple deprivation.

Lower Super Output Areas (LSOA) are areas that display deprivation in the following categories - Income, Employment, Education, skills and training, health deprivation and disability, crime, barriers to housing and living environment decline.

These areas in Tendring were identified by the Business Informatics team as being within Clacton on Sea, Harwich and Jaywick. Of the referrals made during the first month of the project (68 people):

- 56% lived in Clacton on Sea
- 28% lived in Harwich
- 4% lived in Jaywick

Of which:

- 25 out of 68 patients (37%) were in the lowest third of multiple deprivation
- 29 out of 68 patients (43%) were in the middle third of multiple deprivation
- 14 out of 68 patients (20%) were in the upper third of multiple deprivation

Prioritisation of Learning Disability patients

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To improve the outcomes of patients with learning disabilities (LD) we have developed a specific patient tracking list (PTL) which allows the clinical teams to identify LD patient who are awaiting surgery and to bring forward their procedure within their priority group

This specific patient tracking list has now been running for 6 months and the number of patients at any one time on the list is around 60 patients. The patients are reviewed on weekly basis to ensure clinical oversight and input has been included.

Any patients that require additional input from our LD specialist nurses Roger Blake and Stephanie Baker are discussed and flagged to the LD team

Feedback from the LD Nurses shows an improved wait time for patients coming in for surgery and case studies are being gathered to explore any further areas for improvement

Next steps are to evaluate the possibility of extending this prioritisation and support to LD patients awaiting outpatient appointments.

Cancer Referrals Analysis

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1. **ESNEFT receive a higher rate of cancer referrals from the most (Q1) and least (Q5) deprived areas in it's catchment.** The average age of the patient being referred is lower for referrals from areas in Q1 and this is reflective of the broader population demographics.

2. **Deprivation is not a significant predictor of cancer prevalence, after accounting for referral rates**. ESNEFT diagnose more new cancers in patients from the most (Q1) and least (Q5) deprived areas, with trends consistent with the referral rates.

3. **The greater the number of referrals in an area, the more cancer diagnoses there are**. The proportion of referrals leading to a new cancer diagnosis (conversion rate) increases with the number of referrals per capita, suggesting limitations within primary care to accurately diagnose cancers.

4. **Patients from the most deprived areas (Q1 and Q2) have a lower rate of survival at 18 months post diagnoses** relative to the least deprived areas, suggesting a greater severity in the cancer diagnosis and potentially delays in diagnosis relative to other areas. Cancer patients living in the most deprived areas (Q1) have a 47% increased risk of dying within the 18 month period following a new diagnosis after accounting for age, gender and cancer type.

Next Steps

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- **ESNEFT Strategy**: Draft shared with stakeholders, now to go to patient user groups for added input.
- **MECC**: Developing digital options for referrals.
- **MECC**: Patient representation on project team
- Commence **Tobacco Treatment** Project in June
- Expansion of **Nourish** programme to Colchester and Suffolk
- Develop webpage for **healthy eating**
- **DNA rates**: Visits to GP practices to talk to patient about barriers to attending hospital
- Scope equity of access to **Cancer services** and referral rates. Further investigate the relationship between cancer referrals and deprivation.
- Analysis of **lung cancer** data in our most deprived areas
- Further analysis of ethnicity data and data of other vulnerable groups of people
- **Case studies for Learning Disabilities** patients to evaluate experience and review extension of prioritisation programme.