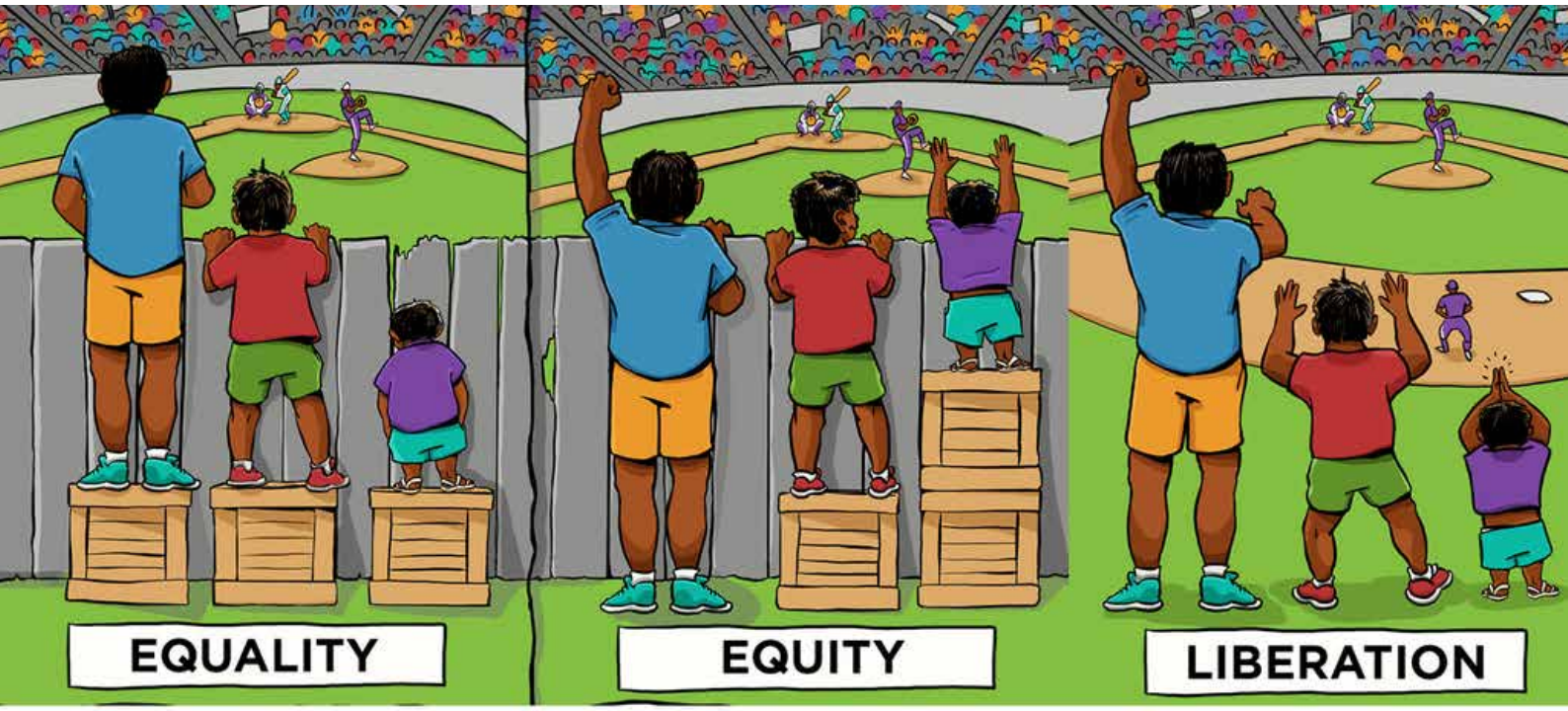
East Suffolk and North Essex NHS Foundation Trust

ESNEFT Addressing Health Inequalities Strategy

Widening Equity for Local Lives



2022/26

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1 Executive summary

Our Addressing Health Inequalities Strategy sets out our vision to close the health inequity gap for our patients and communities across North East Essex and Ipswich and East Suffolk.

Health inequalities are unfair and avoidable differences in health between groups, populations or individuals that arise from the unequal distribution of social, environmental and economic conditions within societies. They influence opportunities for good health and how people think, feel and act, which then subsequently determines the risk of people getting ill and influences the ability to prevent sickness or opportunities to take action and access treatment when ill health occurs[1]. They arise because of the conditions in which we are born, grow, live, work and age.

Covid has brought further challenges for our services and indeed, the patients and communities that we serve. Waiting times are longer, Do not attend (DNA) rates have increased and mortality rates have risen in our communities. These impacts are inequitable, for example Tendring district had the highest COVID mortality rates in England. To meet these challenges, we will work with our communities to understand what matters to them and their experience of the services we provide.

Our ambition outlined in this Strategy is to

“ensure equitable access to our services and improve health outcomes for all our patients”.

Our Strategy has been developed with our staff, partner organisations, community groups and our patients. It recognises that we are part of a complex system of health, care and wellbeing services and that we have a key role in ensuring health inequalities are reduced. This Strategy is aligned with national and local strategies, including the ESNEFT Strategy and the Trust’s strategic objectives namely:

- Keep people in control of their health
- Lead the integration care
- Develop our centres of excellence
- Support and develop our staff
- Drive technology enabled care

This Strategy sets out our ambition and medium-term objectives over the next four years to guide our approach to delivery between 2022 and 2026.

1. https://www.local.gov.uk/sites/default/files/documents/COVID-19%20place%20based%20approach%20to%20reducing%20health%20inequalities%20overview.pdf

This is supported by the following four key objectives:

1. **Get everyone involved in equity**
2. **Identify and monitor health and healthcare inequalities using data**
3. **Understand the causes of inequities and barriers resulting in them**
4. **Create change together with our partners and communities and measure its impact**

We will do this by developing our approaches to population management. Initial programmes of work at ESNEFT to address our ambition include:

- The implementation of a Tobacco Treatment service for our inpatients
- CO15 "Nourish" pilot for children & young people
- Improving Asthma Management Plans for children & young people working with GPs and Pharmacies
- Review and analysis of DNA rates leading to identification of barriers that are driving these rates
- Review and analysis of Cancer referrals, by tumour sites and survival rates in our most deprived areas
- Review of the waiting lists by ethnicity and socio-economic deprivation
- Learning Disabilities prioritisation for elective waiting lists and further expansion to consider other care pathways
- Roll out of Making Every Contact Count (MECC) in outpatient clinics
- Development of a Diagnostic Hub at Clacton, with priority given to Tendring patients
- Development of an Anchor Institution charter
- Implementation of virtual clinics

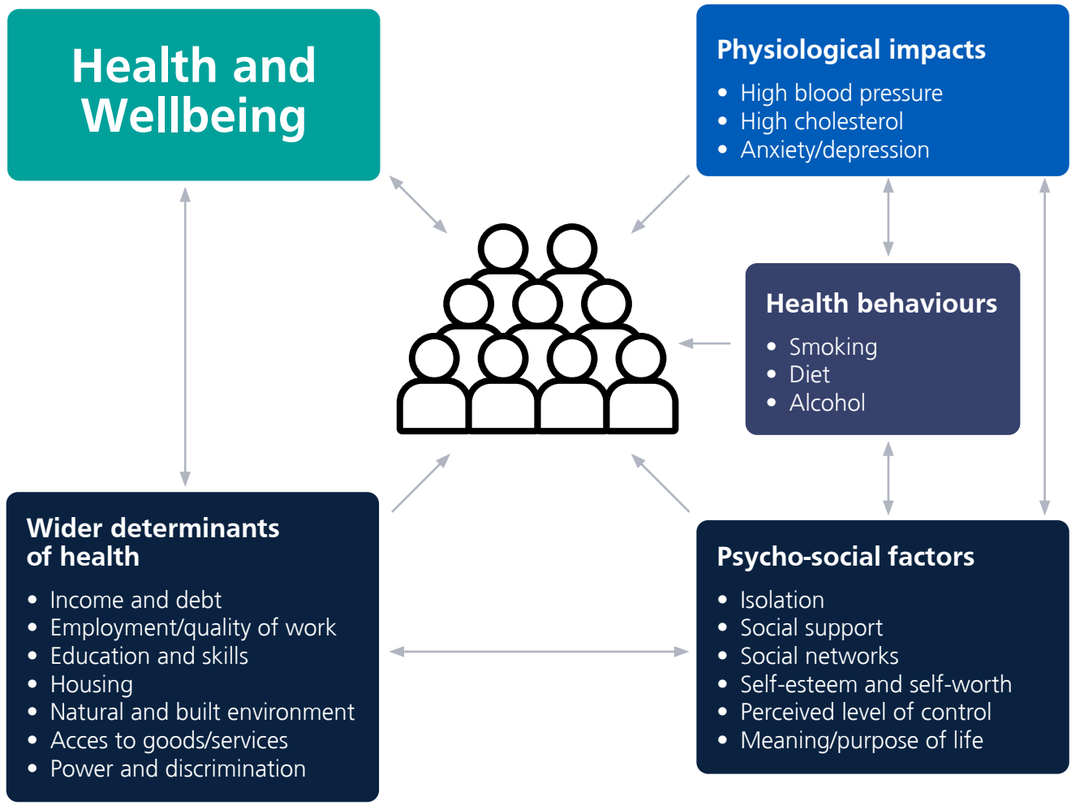
Tobacco Treatment service launch

2 Introduction

2.1 Health inequalities

Health inequalities were already significant and widening pre-pandemic. Stalling in life expectancy has been observed and the gap between population groups growing, with females in the most deprived parts of the country experiencing a decline in life expectancy. There was also an increase in the number of years people were spending in poor health, with a gap in healthy life expectancy of 19 years between the most and least deprived areas in England. The extra costs to the NHS of health inequalities have been estimated as £4.8 billion a year from the greater use of hospitals by people in deprived areas alone, almost 20% of the total hospital budget[2]. COVID-19 has shone a light on health inequalities, replicating existing ones and in some cases further increasing them.

Action on reducing health inequalities requires identifying those with or at risk of the worst health and improving their lives, fastest. Health inequalities are not caused by one single issue, but a complex mix of environmental and social factors which play out in a local area, or place. A conceptual model is provided below of the causes of health inequalities[3]:



Place-based approaches for reducing health inequalities. PHE.

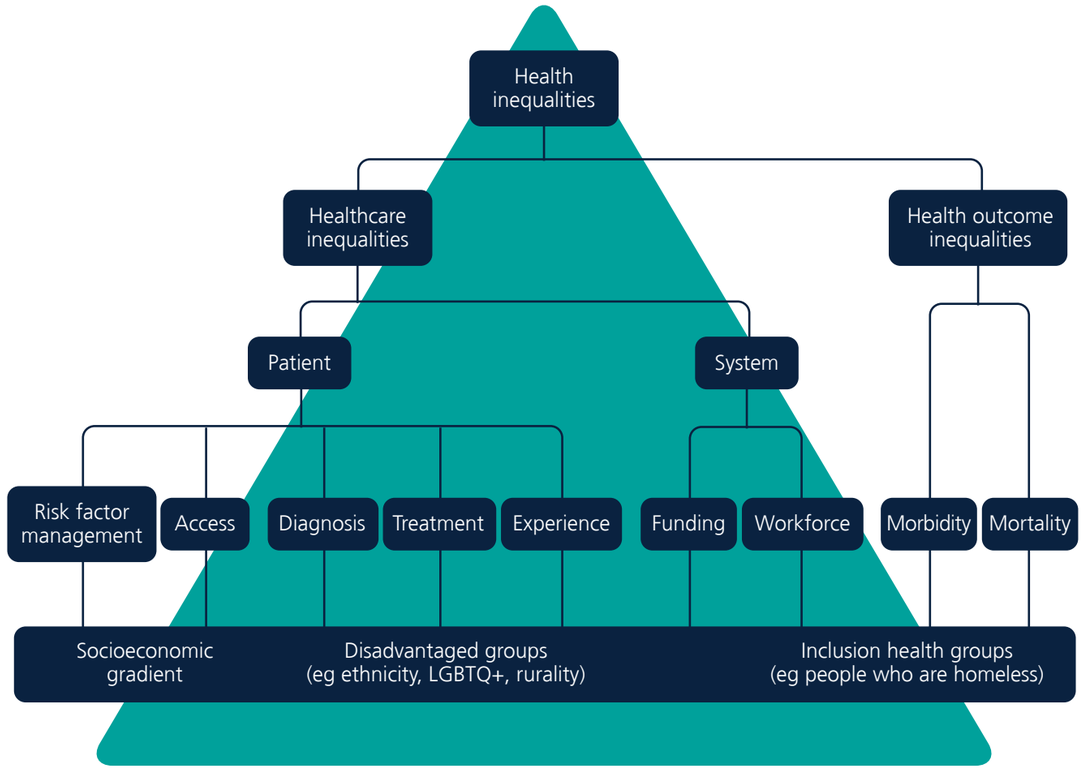
2.https://www.gov.uk/government/publications/health-inequalities-place-based-approaches-to-reduce-inequalities/place-based-approaches-for-reducing-health-inequalities-main-report#fn:2

3.https://www.gov.uk/government/publications/health-inequalities-place-based-approaches-to-reduce-inequalities/place-based-approaches-for-reducing-health-inequalities-main-report#fn:2

There is, therefore, a critical role for local areas to play in reducing health inequalities across the life course, by taking a joined-up place-based approach. This typically involves three components[4]:

- Community-centred interventions (community life, social connections, ensuring people have a voice in local decision making)
- Civic-level interventions (wide-ranging policy functions that impact populations)
- Service-based interventions (focus on services such as addressing unwarranted variability in quality, delivery and use)

However individual organisations also have a role to play in reducing health inequalities. From a healthcare provider perspective, there can be healthcare inequalities impacting on health outcome inequalities through, for example, inequities in access to services, availability of services and experience of services. This is outlined in the framework below[5]:



Transforming health systems to reduce health inequalities. J Ford et al. 2021.

2.2 NHS policy guidance

The NHS Long Term Plan acknowledged the case for acting to reduce health inequalities and set out the key commitments to accelerate action[6]. This was built on in the 2021/22 NHS priorities and operational planning guidance[7,8]. These priority areas were again referenced in the more recent 2022/23 guidance as areas to maintain focus on.

Priority 1: Restore NHS services inclusively

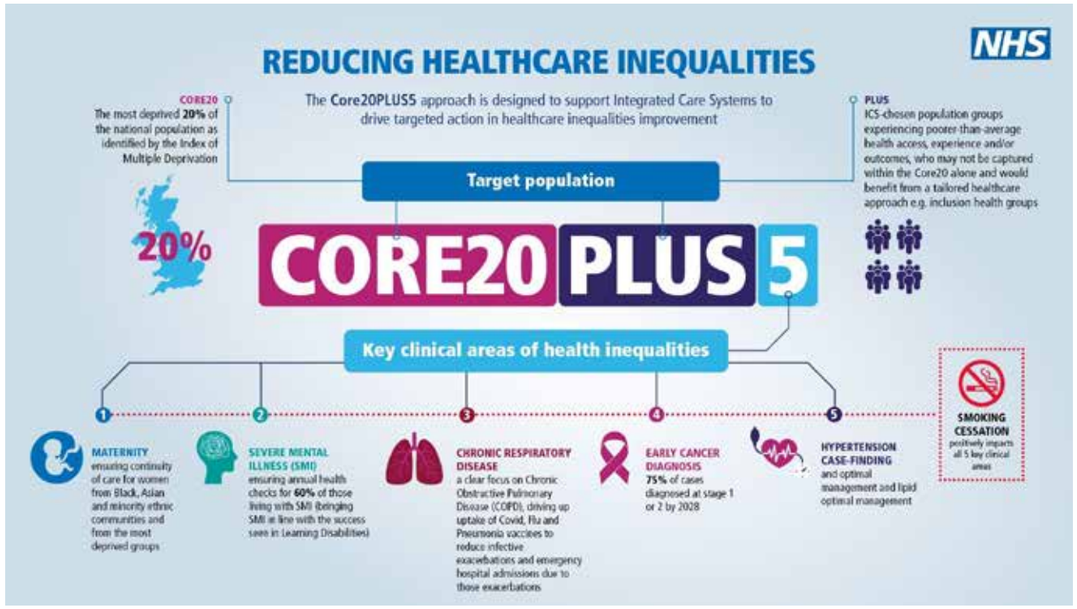
Priority 2: Mitigate against digital exclusion

Priority 3: Ensure datasets are complete and timely

Priority 4: Accelerate preventative programmes that proactively engage those at greatest risk of poor health incomes

Priority 5: Strengthen leadership and accountability

The above priority areas have set the system-wide context for the Core20PLUS5 approach to support the reduction of health inequalities at both the national and integrated care system (ICS) level[9].
A key strategic purpose of ICSs is to tackle inequities in outcomes, experience and access. The approach defines target population cohorts as outlined below and in the infographic:



Core20PLUS5 – An approach to reducing health inequalities, NHS England

4.https://www.gov.uk/government/publications/health-inequalities-place-based-approaches-to-reduce-inequalities/place-based-approaches-for-reducing-health-inequalities-main-report#fn:2

5. https://www.rcpjournals.org/content/futurehosp/8/2/e204

6 https://www.longtermplan.nhs.uk/online-version/chapter-2-more-nhs-action-on-prevention-and-health-inequalities/stronger-nhs-action-on-health-inequalities/

7 https://www.england.nhs.uk/wp-content/uploads/2021/09/C1400-2122-priorites-and-operational-planning-guidance-oct21-march21.pdf

8 https://www.england.nhs.uk/wp-content/uploads/2021/03/B0468-implementation-guidance-21-22-priorities-and-operational-planning-guidance.pdf

9 https://www.england.nhs.uk/about/equality/equality-hub/core20plus5/

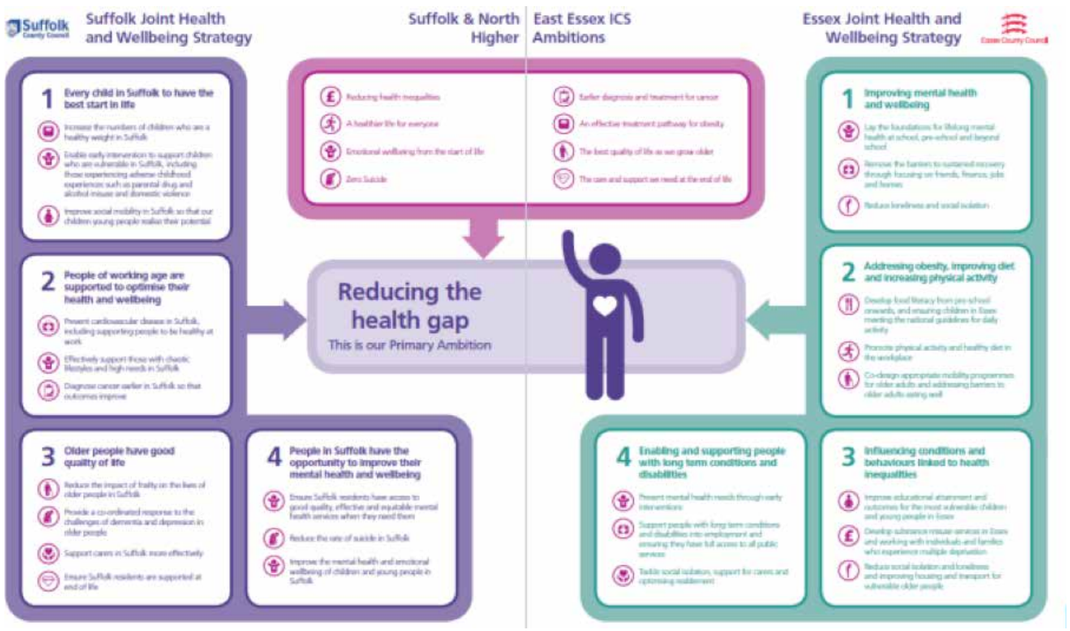
2.3 Role of providers

While multiagency place-based approaches and addressing the wider social determinants of health are critical to reducing health inequalities, as outlined above there are clear roles where providers are able to act within their capacity to support their reduction. The 2022/23 planning guidance highlights the importance of improved data collection and reporting to drive a better understanding of local health inequities in access to services, experience of services and health outcomes. For example it is expected for Trust Board performance packs to be disaggregated by deprivation and ethnicity[10]. This intelligence will then inform the development of action plans to narrow the health inequalities gap.
Example areas for the role of providers include:

- Influencing multiagency action through collaborative working, e.g. with the ICS
- Their role as an anchor institution
- Quality improvement (QI) programmes including an equity focus
- Supporting targeting of healthcare provision to meet local needs and explicitly seek to reduce healthcare inequalities, including patient access, experience and outcomes
- Embedding health equity-focused approaches through champions across programmes

2.4 Suffolk & North East Essex (SNEE)

Reducing health inequalities is a primary ambition for Suffolk and North East Essex ICS. Underpinning the primary ambition of the ICS is everyone having the same life expectancy no matter their circumstances or where they live. A key driver of this is for everyone to have equal access to health and care services regardless of their circumstances or level or deprivation[11]. This is supported by the Joint Health and Wellbeing Strategies for Suffolk and Essex as outlined in the figure below[12].



3 ESNEFT approach

Health inequalities working group

ESNEFT has therefore, established a Health Inequalities Working Group to identify local inequality priorities and to develop mitigations with partners across the local health economy and integrated care system. The aims and ambitions of this group are:

- To work with community partners and the ICS to align approaches and provide tailored support to our communities.
- To implement population health management and personalised care approaches to improve health outcomes and ensure equitable access to our services within our localities
- 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.

Delivery plan

The work of the group is underpinned by a Delivery Plan, developed by adopting the the Core20Plus5 approach and using Making Every Contact Count (MECC) as a tool to support the delivery. There are two components to the delivery plan with associated projects:

1. Risk factor management and health behaviours

- As outlined in the NHS Long term plan, the Implementation of a Tobacco Treatment service for inpatients has been developed and commenced.
- Healthy eating for C&YP: "Nourish" pilot completed in CO15. Scale up and spread into Suffolk being explored.
- Asthma Management for C&YP. Working with GPs and Pharmacies to improve the use of Asthma Management Plans.
- Working with the Alliance Boards to support delivery of the ICS priority domains.

10 https://www.england.nhs.uk/wp-content/uploads/2022/02/20211223-B1160-2022-23-priorities-and-operational-planning-guidance-v3.2.pdf
11 https://www.sneeics.org.uk/higher-ambitions/our-primary-ambition-reducing-health-inequalities/
12 https://adph.org.uk/networks/eastofengland/wp-content/uploads/2020/07/COVID-and-Health-Inequalities-Webinar-FINAL.pdf

2. Equity of Access to services

- Review and analysis of cancer referrals; by tumour site, survival rates and areas of deprivation
- Review and analysis of DNA rates and equity of access for those in our most deprived localities, including qualitative analysis is needed to understand the root causes and experience of services.
- Patients with Learning Disabilities have been prioritised on the waiting lists to allow for timely adjustments
- Patients in the Tendring District (one of our most deprived areas) have been given priority at the Clacton Diagnostic Hub
- Review of services at Community hospitals and accessibility to them

Making Every Contact Count (MECC)

MECC implementation has commenced across the Trust using QI approaches, initially in outpatient clinics. Patients who take up the offer of support are referred to community providers for tailored support, eg weight management, smoking cessation, financial support and mental health services.

Plan underway to expand into community settings taking a 'whole family' approach and linking in to the Social Prescribers.

Main Outpatient team at Colchester where MECC has been rolled out

Our role as an Anchor Organisation

As well as providing health care services, the NHS can use its resources and influence to maximise its social, economic an environmental impacts to improve the social determinants of health, health outcomes and reduce inequalities. For example ESNEFT has been successful in securing provider status for apprenticeships, developed the Clacton Diagnostic Training Academy for local adults who are not in employment or education and launched our inaugural internship programme for SEN students with Suffolk New College.

4 Strategic success measures

Extensive data analysis has been undertaken to explore and understand:

- Obesity in our localities
- Smoking prevalence
- Covid and deprivation
- Elective inpatient and waiting lists ethnicity
- A&E activity inequality analysis
- DNA and cancellation rates
- Cancer referrals/diagnoses

The findings have been used to drive and inform the work of the Health Inequalities Group. Ongoing data analysis and insight will continue to ensure we understand the health inequalities seen in our area, our priority population groups and review the work done by the group.

Success of this Strategy will be monitored through quantitative and qualitative approaches.

Key Performance Indicators

Quantitative measures:

- Tobacco Treatment: All inpatients to receive smoking cessation support by 2024
- MECC: Uptake of referrals to support lifestyle changes
- Reduction in DNA rates from those in our most deprived areas
- Reduction in ED attendance from our most deprived areas
- Proportion of diagnostics performed in Clacton for the Tendring population
- Improved survival rates for patients diagnosed with lung cancer in areas of deprivation
- 75% of cancer cases diagnosed at Stages 1 or 2 by 2028

Qualitative measures:

- Patient stories from those on the Tobacco Treatment Programme
- Patient feedback when receiving support via MECC clinics
- Increase in self-esteem (Rosenberg Self Esteem Tool) for those taking part in Nourish programme