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NHS
East Suffolk and
North Essex
NHS Foundation Trust

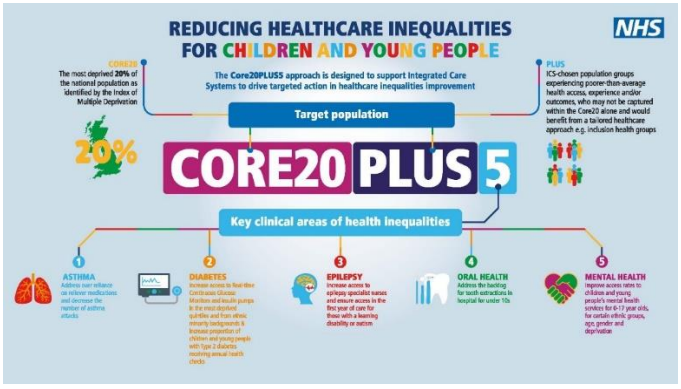
Health Inequalities Programme

Contents

Section 1 – Executive Summary

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).

The CORE20PLUS5 approach, for adults and children & young people, was developed as a national approach to tackling healthcare inequalities.



What are we doing to tackle health inequalities?

In January 2023, ESNEFT launched its four year Health Inequalities strategy which aims to improve the health of local people and equity of access to our services.

This is supported by four key objectives:

- Get everyone involved in equity
- Identify and monitor health and healthcare inequalities using data
- Understand the causes of inequities and barriers resulting from them
- Create change together with our partners and communities and measure its impact

A programme has been developed based on health population data and by listening to our communities, patients and staff to tackle health inequalities. The Programme Executive Senior Responsible Officer is Dr Angela Tillett, Deputy Chief Medical Officer.

Progress on delivery of the programme is reported to the Health Inequalities Programme group which has representation from across the system. Reporting is also, via the Clinical Governance framework and ultimately to Quality Patient Safety Committee. Projects requiring specific clinical engagement are presented to the Clinical Reference group for recommendation and steer.

Across Suffolk & North East Essex (SNEE), 12.5% of local areas (Lower Layer Super Output Areas) fall into the 20% most deprived areas, as identified by national Index of Multiple Deprivation data, including the Brooklands and Broadway areas of Jaywick which are the most deprived LSOAs in the country.

There are 116,673 people in SNEE that live in the 20% most deprived areas nationally, of which the majority live in Tendring and Ipswich.

As set out in the CORE20PLUS5 approach, the SNEE Joint Forward Plan highlights the "PLUS" groups for our Integrated Care System (ICS), namely communities that are experiencing poorer than average health outcomes. These are:

- Minority/Ethnic communities
- Coastal and rural communities
- Groups at risk of disadvantage (e.g. travellers, migrants and homeless)
- People with learning disabilities or autism
- People with more than one health condition.

The projects within our programme are mapped to these where appropriate, although the main focus has been on the CORE20 element, (most deprived 20%) our areas of deprivation to date.

Key deliverables of the programme over the past year include:

- **52%** Quit rate for Inpatient Tobacco Treatment service since commencement
- Over **1800** Referrals made to the Tobacco Treatment service since it started
- Implementation of **CoSTED** Tobacco Dependency roles at both acute Emergency Departments
- Over **50,000** offers of support being made via MECC
- **7,550** referrals made to wellbeing services as a result of MECC conversation
- **Nourish in IP1 Central Ipswich,** completed, showing reduced BP, increased Physical Activity levels and improved self-esteem for C&YP that participated
- **Inpatient pictorial menus** designed and delivered across both acute sites
- **Park & Ride discount** for patients secured permanently for Colchester Hospital patients
- **Asthma Outreach Nurses** recruited. Thirteen asthma reviews conducted since February 25 in Clacton. Engagement with central Ipswich Practices has also commenced.
- **GPPC Hypertension "Healthy Hearts" project** – 5,113 patients with unmanaged hypertension identified and 372 of high risk patients contacted NEE
- **Frailty management service** developed with Ranworth PCN in Clacton – successful one year pilot with outcomes including: 22% reduction of acute appointments (primary care); 13% reduction in routine appointments (primary care); 7.5% reduction in ED attendances.
- **Health Inequalities Awareness sessions** underway and delivered to 336 ESNEFT staff and Senior Leaders since September 2024
- **Six Community Engagement** events delivered in our areas of deprivation in collaboration with system and VCFSE partners, three in central Ipswich and three in CO15. More than 30 individuals with high or very high blood pressure were identified as a result of a BP check during the events.
- **Funding secured for an additional "Hospital Hopper**" to enable Tendring Community Transport to support our patients attend their appointments

In 2024/25 the Hospital Charity identified a fund specifically for addressing health inequalities and this has been utilised across the year to support transport provision in one of our deprived areas, and the inpatient menus to support patients with learning difficulties and cognitive impairment.

Funding for health inequality initiatives and substantive team roles remains a risk, however support has been secured from the North East Essex Alliance for 2025/26 for the team. This will ensure sustainability of the already established projects and support further expansion of the programme, system wide.

Section 2 – Meet the Team

The Health Inequalities team is a small team based cross-site. The team is mainly externally funded with fixed term contracts. Roles have evolved over the past two years and changes will be implemented for 2025/26 to include the newly introduced Partnerships & Engagement Manager role.

Sally Barber – Associate Director QI, Health Inequalities and Medical Directorate

Angie Tillett - Health Inequalities Lead

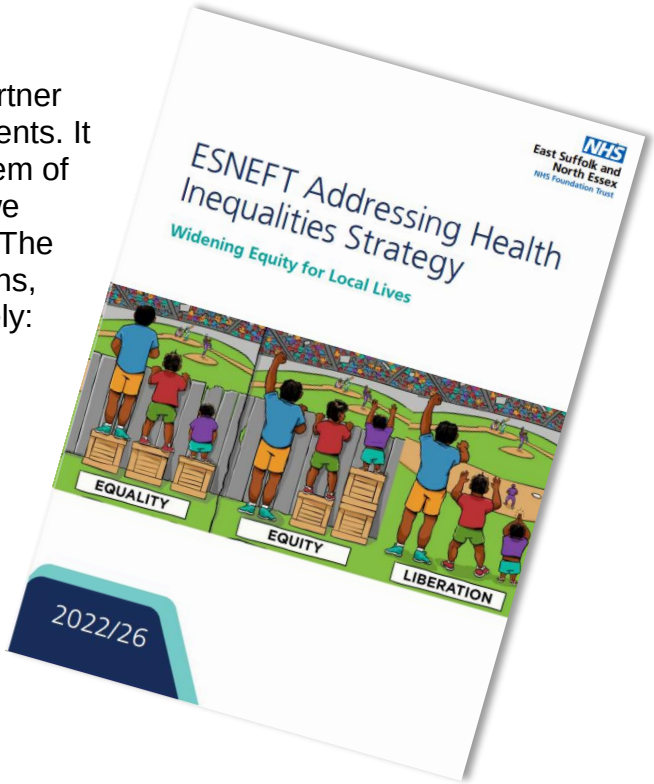
Bryan Gasson - Tobacco Treatment Service Project Manager

Rachel Coles – 'Making Every Contact Count' Project Manager

Iman Mortagy – Health Inequalities Project Support Officer

Section 3 – Strategy

The Strategy was 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 tackling health inequalities. The Strategy aligns with national and local ambitions, including 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

The Health Inequalities Strategy sets out our ambition and medium-term objectives over four years to guide our approach to reducing health inequalities between 2022 and 2026.

The priority areas, defined by the NHS Long Term Plan have set the system-wide context for the Core20PLUS5 approach to support the reduction of health inequalities at both national and integrated care system (ICS) level, using population health management approaches.

ESNEFT established a Health Inequalities Programme Group to identify local inequality priorities and to work with partners across the local health economy and integrated care system to address these. 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.

Our Communities & what the data tells us*:

Smoking, obesity rates and diabetes prevalence are all key indicators used to measure trends in population health. Smoking is the biggest preventable cause of death and obesity increases the risk of chronic diseases such as Type 2 Diabetes and heart disease.

Smoking rates

23.8% of people living in the most deprived neighbourhoods were smokers in 2021, compared with 6.8% living in the least deprived neighbourhoods.

Obesity rates

The level of obesity at year 6 for the most deprived decile of children is almost double that of the least deprived across Suffolk, this is over double compared to the least deprived across Essex, and over five times as high for severe obesity prevalence. North East Essex has a slightly higher proportion and Suffolk a slightly lower proportion of overweight or obese adults aged 18+ than England and the East of England region.

Diabetes

Diabetes prevalence in the East of England is 6.9%. However, in our areas of deprivation, Tendring is 9.1% and Ipswich 9.4%.

There is a life expectancy gap between individuals born in the most deprived communities in SNEE and those in the least deprived. The difference in average life expectancy is 7.4 years in men and 5.9 years in women. 24% of children in Tendring live in low-income families.

*figures taken from the SNEE (ICB) Joint Forward Plan (Joint Forward Plan - NHS Suffolk and North East Essex ICB)

What the ESNEFT data tells us:

Patients living in more deprived areas (IMD Q1) are between 50% and 60% more likely to attend the ED & UTC

Did Not Attend (DNA) rate for patients from our most deprived area, CO15 is 7.5% and 6.2% from IP1 (ESNEFT average is 5.3%)

At both Ipswich and Colchester, patients from ethnic backgrounds, other than white British, are twice as likely to attend the ED and UTC

Cancer diagnosed following emergency admission is 2.5 times higher for patients living in deprived areas

Section 4 – Programme Updates & Achievements

Tobacco Treatment Service

CORE20 PLUS 5

Inpatient Service

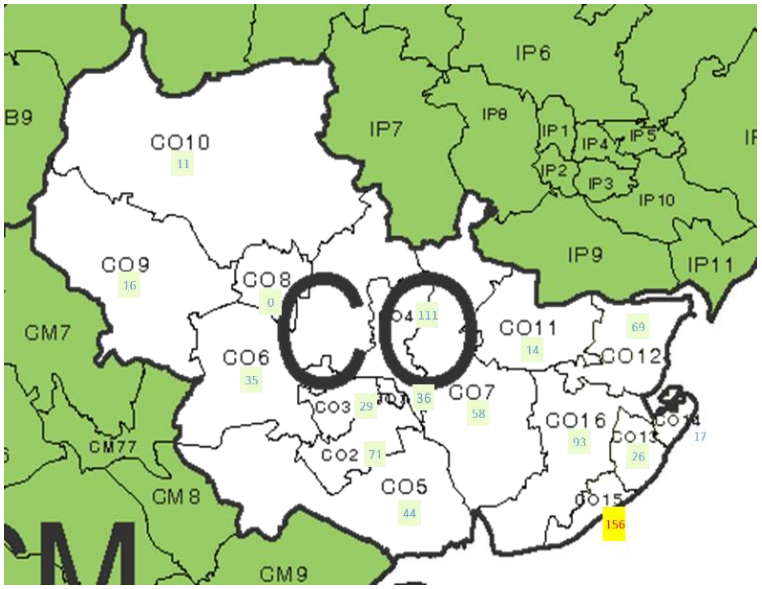
The Inpatient Tobacco Treatment Service was rolled out across Colchester and Ipswich Hospitals at the end of 2022, with each hospital having 2 full time Tobacco Dependency Advisors delivering the service to patients at the bedside.

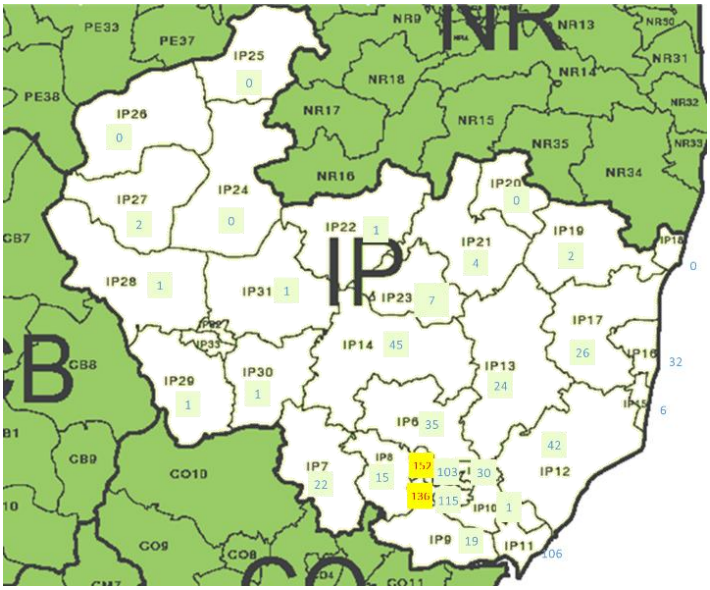
Since the service's implementation, 1800 patients have been referred to the service, translating into just over a 52% quit rate (at 28 days) of those patients assessed by the team, comparing to a National average of around 55-57%. Whilst the need to continuously promote the core inpatient service remains, 2024/25 has seen the service consolidate the offer to support patients attending specialist clinics and pre-operative appointments. The service has been brought in-house with effect from 1 April 2025.

The service works closely with our maternity colleagues who are also running a smoking cessation service to reduce "smoking at time of delivery" rates and have successfully exceeded national targets.

Tobacco Treatment Service Statistics (start of service to Mar 25)

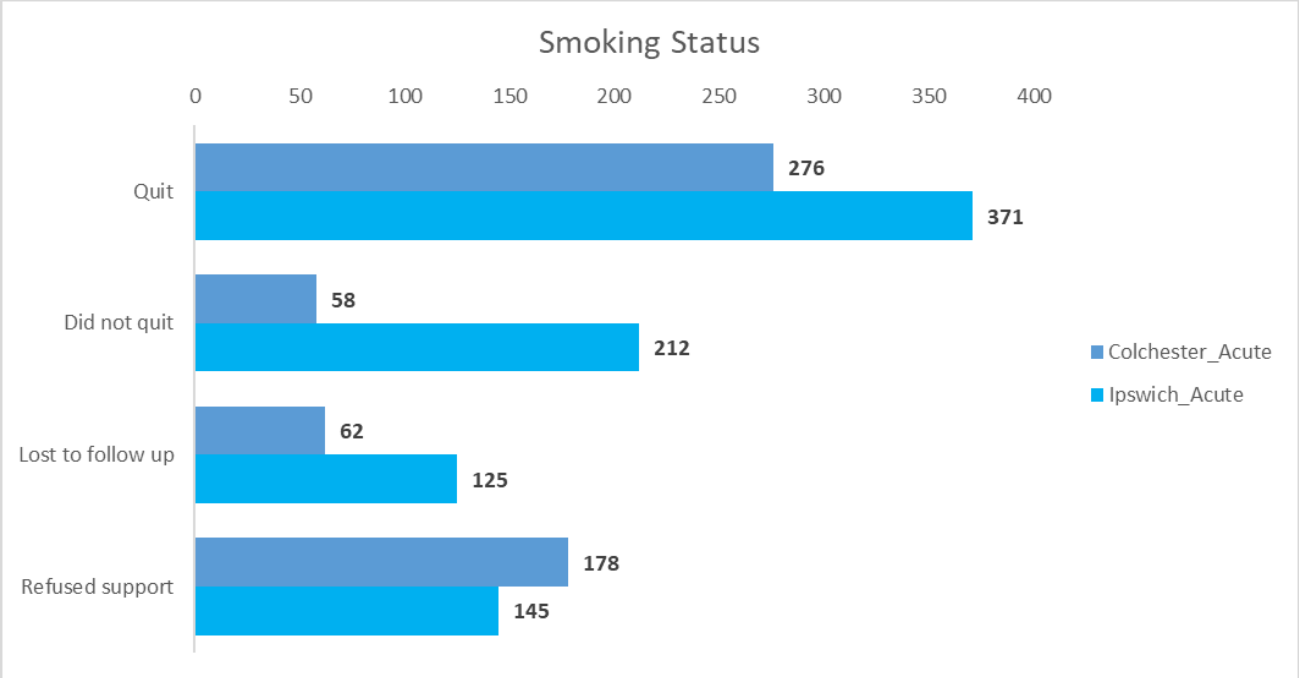
Postcode maps of referred patients = highest referral rates from most deprived areas (Clacton and central Ipswich)



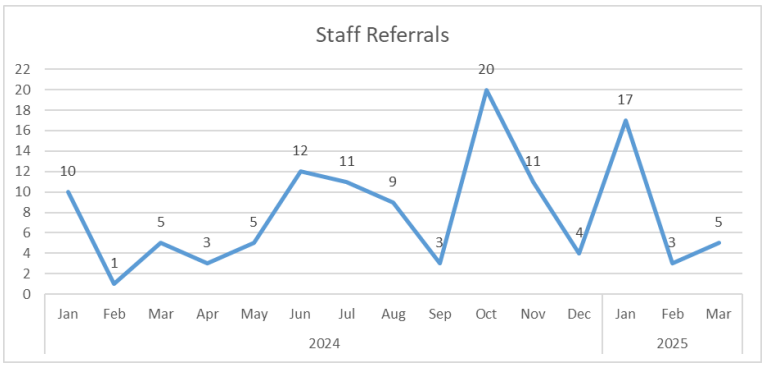


Total monthly referrals to Tobacco Treatment Service:

Smoking status of referred patients 28days after they've taken up support



Staff Service



In November 2023, the team expanded by recruiting an additional Tobacco Dependency Advisor to provide a Stop Smoking Service to all ESNEFT staff wanting to quit. This service also supports the parents and carers of paediatric and neonatal patients. 78 of the 114 ESNEFT staff referred have quit smoking as a result of this initiative.

New Service for our ED Departments

In January 2025 a new pilot was introduced in our Emergency Departments (CoSTED) at both acute hospitals, funded for one year from Smoke Free Generation funding. The service will engage with patients and members of the public attending ED, offering them a free 4-week course of vapes or Nicotine replacement therapy to encourage people to stop smoking. The service is fully recruited to with two TDAs at each site.

Picture right: Helen Campbell-White, one of the four new TDAs based in our acute EDs, to promote the 'Swap to Stop' initiative

Picture above: TDA Ruth Gray conducting a bedside conversation with an inpatient about smoking cessation

Patient Feedback

"Whilst I was in hospital, and having asked for help, within a couple of days, Carolina came to see me on more than occasion. She fully supported me, provided me with products, and websites for further assistance. Carolina was encouraging, non-judgemental and, once discharged, I regularly received follow-up calls from her. I found her very easy to talk to, and she has a wonderful sense of humour. I was indeed very fortunate to have met such a delightful person. Thank you Carolina, for all your kind help, and I know I can contact you again should I need to"

Making Every Contact Count

CORE20PLUS5 CORE20PLUS5

Making Every Contact Count (MECC) is simply a chat and offer of support about health. A MECC conversation is a very brief intervention – no specific knowledge or expertise about the subject area is required. They are often about 'planting a seed' for change or supporting someone to make a small step towards making a change.

MECC was initially piloted in our Main Outpatient Department (OPD) at Colchester Hospital in October 2021, and since then the footprint has grown to include over 45 specialities and 300 (cumulative) clinics. Core delivery is still via outpatients and work continues to increase the footprint to additional areas and specialities with a focus on consistently offering support within each area.

To date, over 50,000 offers of support have been made with more than 7750 referrals sent to our external providers by OPD Nursing teams.

The OPD Nursing teams in Main, Gainsborough, Primary Care Centre (ENT & Oral), Clacton & Harwich Community Hospitals and also Clinic A at Ipswich Hospital have embraced MECC and are offering additional support to their patients every day.

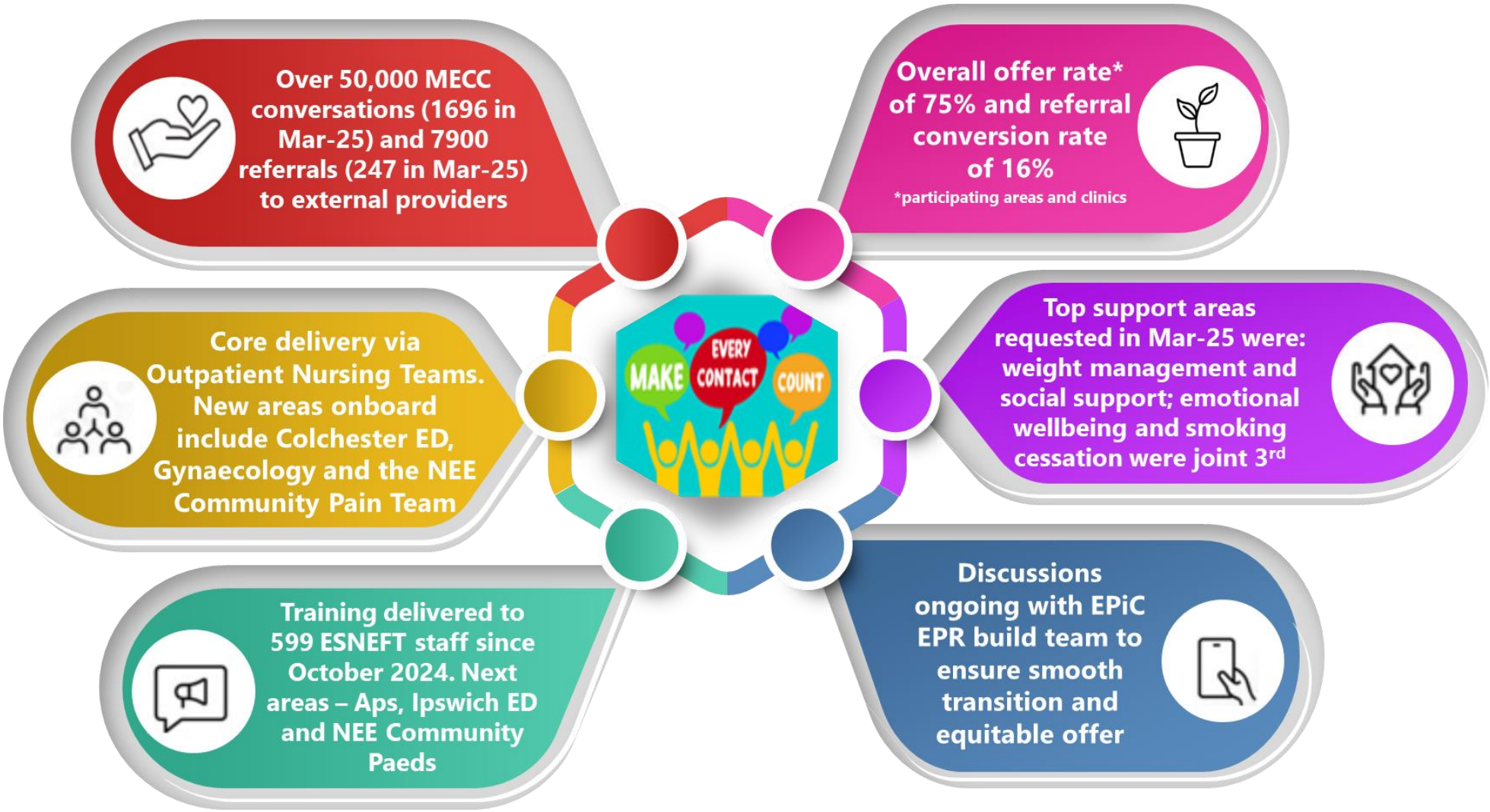
Picture above: HCA Cherrelle Cody during a MECC conversation in Gainsborough OPD

Embedding MECC more widely within ESNEFT

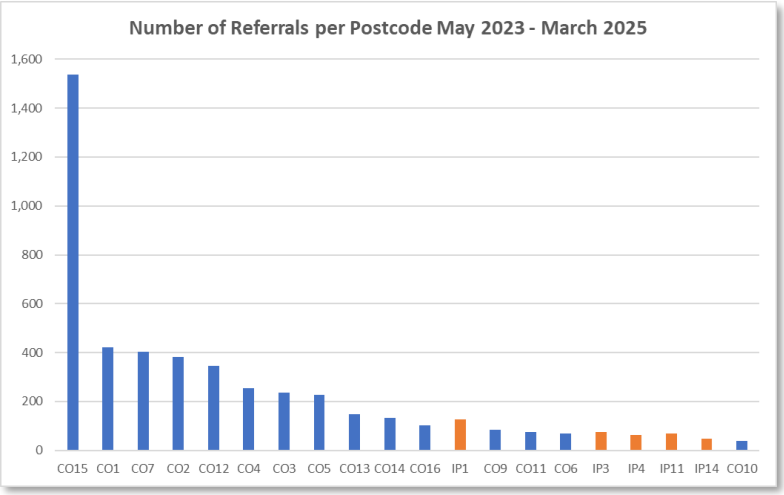
A bespoke ESNEFT MECC training module has been developed that can be tailored to any work area or specialty. Focussing on MECC awareness and a 'how to' for referrals, we have trained more than 500 ESNEFT staff since August 2024. Teams that have now received this awareness training include ED (Nursing and Doctors), Colchester and Clacton UTCs and the recently opened Elective Orthopaedic Surgery Centre (ESEOC) where we piloted an MDT approach to get everyone on board and 'thinking MECC'. This includes close working with the newly appointed 'Waiting Well Practitioner'.

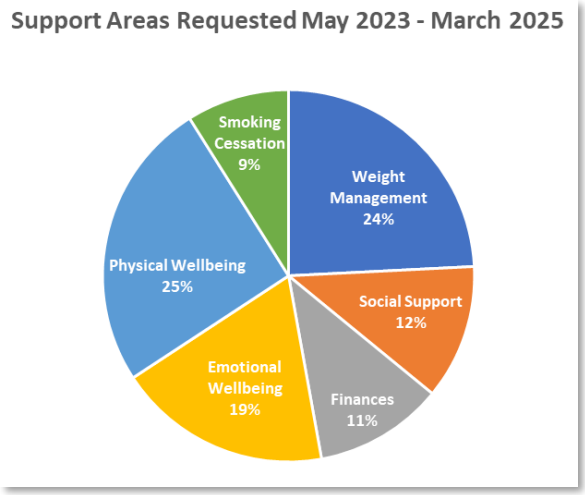
Data collection varies by area and is dependent on the systems used by staff. Referral numbers to our external providers are being monitored for the areas that currently use Evolve. NEE Community Services teams that use SystmOne are able to monitor numbers of MECC offers/conversations. Development is in progress for data collection mechanisms with Epic EPR.

At a Glance MECC Reporting



Making Every Contact Count Outcomes and Statistics

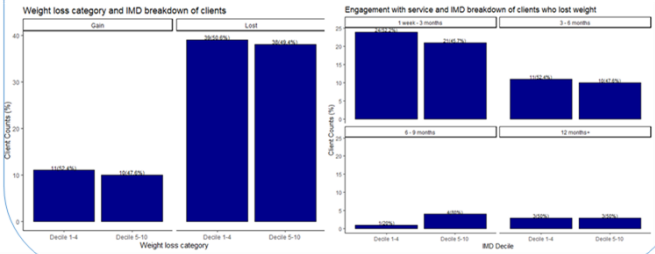




Selection of feedback from Essex County Council evaluation of MECC initiative at ESNEFT, published in November 2024:

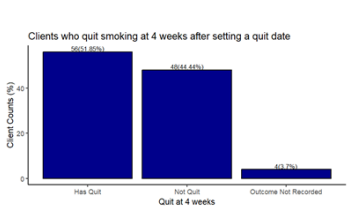
Weight Management Outcomes

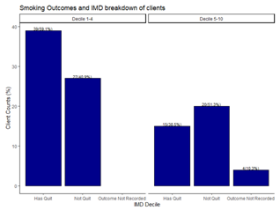
- Data was available for 97 individual clients who engaged with the service for 1 week or more
- The majority lost weight between baseline and current weight (N=78, 80.4%, while 18.6% gained weight (N=18) The remaining one person (1%) maintained their baseline weight



Smoking Cessation Outcomes

- 108 clients referred to a smoking cessation service set a 4-week quit date
- Among those who set a quit date, just over half (N = 56, 51.9%) reported quitting smoking at 4 weeks
- Overall, slightly more individuals living in more deprived areas (IMD Deciles 1-4) reported quitting smoking at 4 weeks compared to those living in the lesser deprived areas (IMD Decile 5-10)





Found the referral process easy as hospital staff assisted me. It was suggested to me that I used EWS as I was coming to the end of my physio sessions, and I had commented that I would like assistance with a few things to make life easier at home

I needed to feel more in control when mobilising around my home, and although I have only had a couple of sessions, I am starting to feel more confident

The service of the community agent was great, I got all the support that I needed…I don't think I would have had my assessment so soon if the community agent hadn't helped us contact them. The community agent came to my home and understood my needs.

Nourish (CYP Healthy Eating Programme)

CORE20 PLUS 5
CHILDREN AND YOUNG PEOPLE

Nourish is an ESNEFT designed 20 week weight management programme for children (7-16yrs) who fit the BMI eligibility criteria and live with co-morbidities related to excess weight, such as Diabetes.

The programme was led by Divisional Director Consultant Paediatrician, Youth Worker, and Dietician, partnering with Physical Activity instructors to support delivery.

Plans are underway to expand this programme for 2025/26.

Nourish in IP1

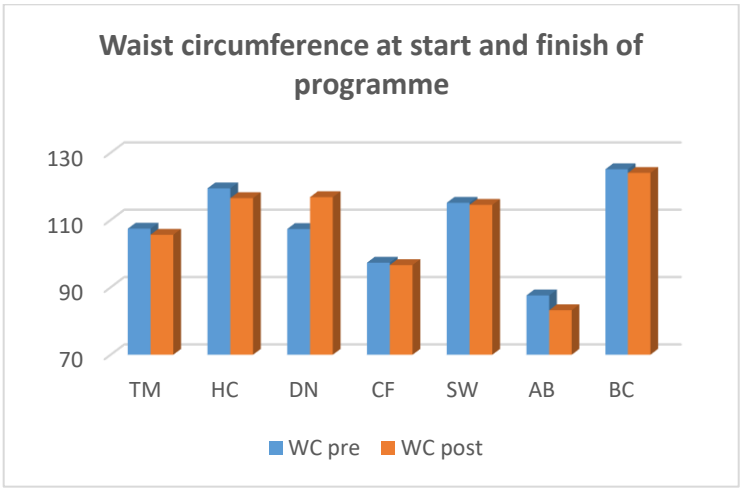
Following on from the success of the Nourish Programme that took place in CO15 in 2022, a second programme for children and young people living in IP1 was launched in September 2023 at the Unity Centre in Ipswich. Support for physical activity was provided by Inspire Suffolk. This 20 week programme concluded in April 2024.

Involvement of Inspire included midweek support to sustain physical activity between programme sessions. Inspire are also supporting the CYP and families after the programme has completed. The families found weekly exercise charts & programmes helpful. Positive feedback was obtained from participants & children.

Outcomes

Young people taking part reported:

- Increased physical activity on weekly basis
- Beneficial changes to dietary intake to reduce refined sugar and saturated fat
- Increased fruit and vegetable intake
- Change to healthier snacking
- Reported increased mental health / wellbeing
- 6/7 children had a reduction in waist circumference



NOURISH
improving physical and mental health
NHS
East Suffolk and
North Essex
NHS Foundation Trust

Adult Healthy Eating

CORE20PLUS5

To ensure we maximise all opportunities to offer and promote healthy eating for our patients and staff we have undertaken multiple actions that support making healthy choices. This included:

- The roll out of pictorial inpatient menus at both acute sites to better indicate specialist dietary requirements for “at risk” patients and those with learning difficulties or visual impairment
- Planned community engagement events undertaken, linking with community and system partners including cooking demonstrations using ESNEFT chefs
- Linking with hypertension and diabetes programmes ICS wide
- Weight management offered as part of MECC
- Volunteer role developed to support inpatients at mealtimes

Inpatient Menus

Following a collaboration with clinical teams across the Trust, pictorial menus were launched both acute sites in Spring 2024, funded from the Health Inequalities charitable fund Feedback from both patients and staff has been gathered and overwhelming positive.

After the roll out, 100% of staff we surveyed agreed that the inclusion of pictorial menus had been beneficial in their opinion.
Comments we gathered from patients to determine their views on the menus included *“Looking at the pictures builds up the appetite.”* and *“The menu is clear and really helpful.”*

Picture above: Staff on Peldon Ward in Colchester with the new menus

Picture above: Kelly Barker from Voluntary Services with Mealtime Volunteer Sue Cotton

Mealtime Volunteers

By working with ESNEFT’s Voluntary Services team we now have an established Mealtime Volunteer role which is offered as part of their portfolio of opportunities. This role has proved to be both challenging and rewarding for those who are now in place on our wards. Some patients may find it difficult to understand menu options, e.g. patients with confusion or dementia, visual impairment or learning difficulties. This ward based role supports patients with making food choices and eating.

Improving Access – understanding Did Not Attend (DNA) Rates Project

CORE20PLUS5

By listening to residents in the community we embarked on various activities to improve access, increase provision and reduce cost of travel for our patients. Access to affordable and accessible transport is a known factor negatively impacting attendance rates at hospitals. The DNA working group continues to investigate DNA rates mapped by patient postcodes at our hospitals and seek multi-faceted solutions and interventions to address these access challenges.

Work is underway with clinical teams to explore opportunities of taking more services to Clacton Hospital. We are supporting with funding applications for equipment for additional diagnostic clinics at Clacton, as well as working with local authorities, community groups and system partners to develop solutions for affordable transport.

Patient Transport

In March 2025 we secured funding from Colchester & Ipswich Hospital Charity for an additional Hospital Hopper. This bus is operated by Tendring Community Transport and exists to bring patients from Tendring, specifically Clacton and Jaywick to their hospital appointments at Colchester Hospital and other health settings. The charity awarded a dedicated fund to the Health Inequalities programme in recognition of the significance and impact of our targeted programme of work.

Above: Tendring Community Transport's buses

Picture, below: Flyer to promote Park & Ride discount for patients

Park & Ride

After a successful pilot of a discounted Park & Ride fare at Colchester, Essex County Council have now confirmed this as a permanent offer. This enables patients (and one other person) in possession of an appointment letter to use the Colchester Park and Ride for £1.50 each. This also relieves pressure on parking availability at the hospital and enables the release of additional spaces for the benefit of our less mobile patients.

Asthma in Children and Young People Project

CORE20 PLUS 5
CHILDREN AND YOUNG PEOPLE

Data acquired both nationally and via our Business Informatics colleagues informed us that our local areas of high deprivation suffer with disproportionate asthma provision for children and young people.

Working alongside our Consultant in Allergy and Paediatric Respiratory Medicine and supported by our Community Paediatric Matron, we secured funding for two specialist outreach nurses to work in our most deprived communities. Their role is to improve outcomes for some of our most vulnerable children and we have initially partnered with a PCN in CO15 and IP1 to identify patients most at risk and put in place Asthma reviews.

Picture right: Our new Asthma Outreach Nurse Rebecca Baldry with our partners at Ranworth PCN in Clacton on Sea

Asthma Outreach Activities

Picture above: Rebecca at one of our outreach events in Jaywick in Nov 2024 with our learning disability specialist, Steph Baker

One of the aims of these roles is to work with parents and carers, schools, primary care pharmacies and in community settings to identify and support with a range of activities to enhance asthma care. These activities include:

- training and information for clinical staff working in primary care
- working with families to ensure adequate asthma management plans are in place
- working in the community i.e. schools and wellbeing hubs, to inform and support with learning around respiratory health
- working with school children to co-produce education and learning packages

The project commenced in February 2025 and 13 reviews have taken place across February and March.

By engaging with GP surgeries in CO15 and IP1 we have also delivered Lunch and Learn sessions to Practice staff. We have also contacted schools in these areas to roll out a programme of staff and pupil training events to educate and inform on the subject of asthma management.

Community Engagement Events

Six community engagement events were held in 2024-25 in Central Ipswich and Clacton bringing vital health resources and education to communities in need. The events, aimed to address the health inequalities faced by local residents and to empower them with the knowledge and tools to improve their well-being.

Picture above: Child Immunisation Nurse, Terella Adams

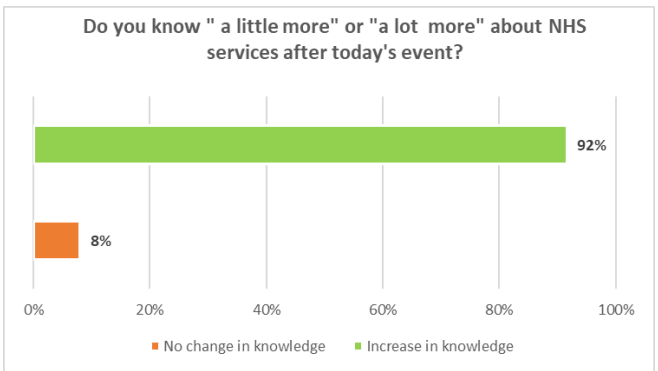
Picture above: Clacton event in July 2024 with Open Road

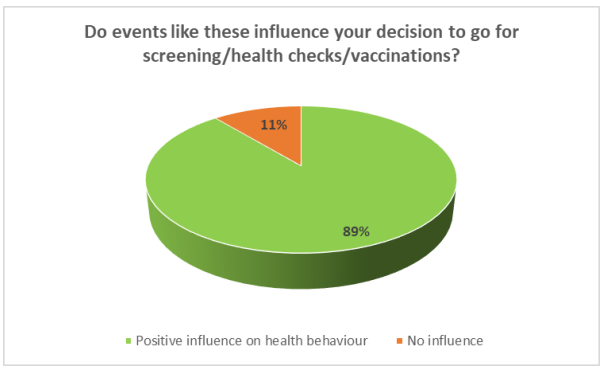
Picture above: Ipswich event in March 2025 with the Be Well Bus

With support from various ESNEFT teams, the SNEE Be Well Bus (Ipswich events), Open Road SOS bus (Clacton events), ICB & Alliance partners, voluntary sector and community organisations, the events offered free health checks, advice on cancer awareness and screening, and signposting on topics ranging from tobacco cessation to dental care. Many residents in these areas struggle with access to services and these events are vital to reach communities that are often underserved.

The CORE20Plus5 areas were the focus for these events – particularly screening uptake and identification of new hypertension cases. The events were attended by over 450 people and 71 feedback questionnaires were completed. More than 30 individuals with high or very high blood pressure were identified. There were 150 conversations documented between attendees and our specialist screening practitioners (ESNEFT Bowel Screening; ESNEFT Breast Screening; Suffolk GP Federation Cervical Screening), and 89% of those surveyed said these events had positively influenced their decision making around attending screening, health checks or vaccinations.

Feedback questionnaire responses





Health Inequalities Awareness Sessions

Raising awareness of Health Inequalities across the Trust is vital to enable positive change. Our staff play a key role in supporting the reduction of health inequalities and frontline staff provide vital insights on the issues affecting our patients and communities. We developed an interactive one hour session for all staff that informs and empowers leaders and clinicians to identify health inequalities and ways to tackle them. Included in this session:

- Existing statutory duties placed on NHS organisations and outlines current guidance on health inequalities.
- Helps identify barriers and enablers to systems that prioritise tackling health inequalities
- Local population health data and details of our own informatics that highlight areas of concern
- Highlights actions that clinicians and leaders could take to address health inequalities in their service areas and by listening to patients.

Online Training and Away Days

Awareness sessions are now underway at both acute sites and the team have also presented at MDT Governance days as well as Resident Doctors' training days.

Feedback from participants is now being collated with various positive changes being reported. This includes the introduction of a new initiative at the Community Diagnostic Centre in Clacton focused on proactive case finding for oesophageal cancer as a result of participating in one of our sessions.

Picture, right: The MSK team at Ipswich take part in a Health Inequalities Awareness Session.

Section 5 - KPI Dashboard

Tobacco Treatment Service and MECC KPIs:

			Q1 24/25			Q2 24/25			Q3 24/25			Q4 24/25					
Ref	KPI	Target	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Average (Last 6 months)	Baseline	Comments
TT1	No of referrals made to Tobacco Treatment service	N/A	62	62	47	41	31	59	84	86	67	105	76	76	82	0	Total referrals since service commenced in July 22: 1800
TT2	Quit Rate	>55 = Green >40 - <54.9 = Amber <39.9 = Red 70%	31.82%	48.89%	54.84%	62.50%	30.77%	47.06%	49.06%	46.15%	55.00%	52.54%	48.72%	47.06%	49.66%	0	Data reviewed identified anomolies in quit rate calculations. With new amended criteria, the service exceeded target in 2024/25. New target of 70% set for 2025/26 to reflect this
TT3	Number of patients taking up support/Number of patients referred appropriately	>80 = Green >50 - <79.9 = Amber <49.9 = Red 80%	70%			68%			60%			62%			N/A	70%	Target is 80%
MECC1	MECC Offer Rate (participating OPD Clinics)	>80 = Green >60 - <79 = Amber <59 = Red 80%	74%	77%	76%	72%	72%	67%	78%	76%	73%	82%	80%	79%	78%	80%	Baseline taken from pilot. Outpatients only: Col/Clacton/Harwich/ Ips Clinic A plus TLHC offers. Number of MECC conversations divided by Total no of patients in clinic
MECC2	Total Number of MECC Conversations across the Trust (Offers)	Increase month on month	1738	1821	1591	1624	1284	1275	1562	1338	1044	1580	2084	1616	1529	0	Total MECC offers/conversations recorded Trust-wide: OPD; ESEOC; NEECS; TLHC
MECC3	No. of referrals (OPD Clinics)	Increase month on month	264	242	225	220	146	151	214	157	128	187	186	251	187	0	No of referrals across OPD. Figure should increase as more areas come on board. Outpatients only: Col/Clacton/Harwich /Ips Clinic A
MECC4	No. of referrals (other teams)	Increase month on month	17	16	9	30	31	37	43	20	30	50	35	38	36	0	Taken from ESNEFT BI Referral Report
MECC5	Training Delivery Uptake	700 staff trained per year (175 per quarter)	N/A	N/A	N/A	5			75			457			88	0	589 ESNEFT staff have received MECC awareness and referral training since Aug-24
MECC6	No. new teams onboarded	2 teams per month	N/A	N/A	N/A	N/A	1	0	1	1	2	4	2	4	2.50	0	2 teams a month on average - NB some teams have multiple sessions. Some months, refresher training is conducted for existing teams (not incliuded in figures)

KPI Dashboard continued:

C&YP Asthma Project KPIs (under development):

			Q4 24/25	
Ref	KPI	Target	Feb-25	Mar-25
Asthma1	To reduce ED/UTC attendances of patients from CO15 & 16 by 13% (England mean) based on ESNEFT 23/24 baseline.	EDs and UTCs (GP streaming to be included separately) (CO15 & 16 patients, with Asthma diagnoses - phase 1).	N/A	N/A
Asthma2	a) A reduction of Asthma Admissions from CO15 & 16 patients, of [%], based on ESNEFT 23/24 baseline b) A reducion of Admissions of undiagnosed Asthma (viral wheeze or LRTI) of [%] based on ESNEFT 23/24 baseline	a) Children's Ward/ED/UTC admission with primary diagnoses of asthma b) Children's Ward/ED/UTC admission with Suspected Asthma	N/A	N/A
Asthma3	Increase in new Asthma Management Plans for CO15 & 16 patients	a) Set numeric target based on number of pts seeing each week b) Annual review carried out for Asthmatic patients with a review over 1 year old	6	8
Asthma4	Increase in referrals to smoking cessation services from the household (CO15 & 16)	Number of referrals made to Smoking cessation services via Review	0	1
Asthma5	Reduction in number of CYP prescribed ≥ 6 SABA inhalers in 12 months	Monthly prescriptions of steriod inhaler Reduction in salbutamol prescriptions	TBC	TBC
Asthma6	Number of asthma diagnoses made for query asthma CO15 & 16 patients	Diagnostics via Feno/Spirometry	2	5
Asthma7	Number of GP appointments avoided as direct result of Outreach Nurse intervention	Count of appointments avoided	2	0

Section 6 - Summary

The HI programme has achieved a great deal over the past year with more progress to be made in tackling the inequity in health that our patients across our communities face.

One of the main highlights of the year was increasing our reach to both staff and our communities. The events that have taken place in our communities this year enabled us to further enhance our links with system partners and co-produce meaningful interactions directly with our patient population.

This programme has also linked closely with other HI initiatives across the ICS, to include hypertension. ESNEFT funded the “Healthy Hearts” project for 2 years, being delivered by the GPPC. A frailty management service was set up at Ranworth PCN in Clacton and an alcohol dependency service at Ipswich was also funded for one year and although continuation of the full service was not secured, the service has been bolstered to cover 5 days.

Next year’s Programme Plan has been developed, and co-design of key projects with our patients and communities over the coming year will be pivotal to success. The plan will align with national priorities in the Operational Planning Guidance as well as the 10 Year Plan which is due imminently.

Address inequalities and shift towards prevention	Reduce inequalities in line with the Core20PLUS5 approach for adults and children and young people
	Increase the % of patients with hypertension treated according to NICE guidance, and the % of patients with GP recorded CVD, who have their cholesterol levels managed to NICE guidance

Operational Planning Guidance: National priorities and success measures 25/26

We will continue to ensure that wider system ambitions are considered and aligned with our own programme over the coming year.

Funding for the team roles has been secured from the NEE Alliance, for a further 2 years across 2025/27. A Trust Clinical Health Inequalities lead role has been recruited to support delivery of the programme.

Working with the EPIC team, we have ensured that our programme is ready for the EPIC implementation, in particular our Tobacco Treatment Dependency advisors, who will be able to proactively visit patients that smoke as ‘smoking status’ will now be captured on admission.

Improvement work will continue aligning with Quality Improvement (QI) approaches and using the Model for Improvement in particular will help to shape projects over the coming year. Team members have all attended QI silver training delivered by the ESNEFT QI Team to equip them with tools to deliver change.

Our priority for the coming year is to engage and mobilise divisional teams to consider Health Inequalities as part of their own service reviews and divisional plans. By delivering workshops and training sessions we will ensure that consideration for our own local population health data is central to divisional planning activities.

In conclusion, our commitment to addressing health inequalities remains. Over the past year, we have made significant strides in identifying and reducing disparities in healthcare access, experience and outcomes within our communities.

We recognise that tackling health inequalities is an ongoing journey that requires continuous effort and collaboration. Moving forward, we will continue to work closely with our partners, stakeholders and the communities we serve to build on our successes and address the challenges that remain.

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- IES and NEE Alliances
- Colchester & Ipswich Hospitals Charity
- The University of Essex
- Ranworth Surgeries, Clacton-on-Sea
- Green Elms Surgery, Jaywick
- The Jaywick Community Resource Centre, Clacton-on-Sea
- Tendring Community Transport, Clacton-on-Sea
- Essex County Council
- Essex Wellbeing Service
- Provide CIC
- Open Road, Colchester
- Community 360, Colchester
- Cardinal Medical Practice, Ipswich
- The Unity Centre, Ipswich
- Castle Hill Community Centre (Foodbank), Ipswich
- Suffolk County Council
- OCS
- Connect for Health (The Shaw Trust)
- Cancer Support Suffolk
- Ipswich Community Media
- GP Primary Choice